NHS
Calderdale
Clinical Commissioning Group

Annual Report 2017-18

OUR LOGO EMBRACES ALL OUR VALUES

LONG LIFE
Preventing people from dying prematurely

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

INDEPENDENCE
Helping people to recover and maintain their independence

CARE
Ensuring people have a positive experience of care

PROTECTION
Ensuring a safe environment and protecting people from harm

EQUALITY
Reducing inequalities

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

The Annual Report and Accounts consists of four sections:

1) The Performance Report:

2) The Accountability Report, which consists of:

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

3) Parliamentary Accountability and Audit Report

4) Annual Accounts

The Annual Report and Accounts (2017-18) for NHS Calderdale Clinical Commissioning Group were approved by the Audit Committee on 17 May 2018 under delegated authority from the Governing Body.

Contents

Glossary

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

Introduction to the Annual Report

I have found writing an introduction to this year's annual report difficult. In many respects this has been a successful year for the CCG. We have finished the year having delivered our statutory financial duties and having overseen the delivery of many of the NHS constitutional standards. Even where we have been unable to deliver on the standards our performance as a system has consistently been in the top quartile when compared to other systems nationally. It has been recognised by many that this winter has been the toughest anyone can ever remember and the contribution that has been made by staff across the system has been extraordinary. The NHS has been forced to take exceptional action in order to maintain an urgent and emergency care service for patients, and many people have had operations cancelled and delayed in order to ensure that there was sufficient capacity to deliver hospital care for those whose condition necessitated admission. As chair of the Accident & Emergency Delivery Board for the Calderdale and Huddersfield system I understand well the pressure that this has put upon organisations and the strain that has been placed upon relationships across the year. Despite that we have worked together well, and I am so grateful to all who have contributed to all of that work, much of which has been provided through voluntary effort. Many people have gone the extra mile and done far more than they are paid to do in order to ensure that the system was able to provide a service. Increasingly I am finding myself saying that we are being expected to do an impossible job. And yet we keep doing it. It is an amazing privilege to be part of a system like this one.

I am so proud to be responsible for the organisation of which I am part. People have worked so hard this year in order to deliver the position that is reflected in this report. The focus upon what we are here to do and the people that we are here to serve, the spirit that is part of the way we choose to be, the willingness to support one another and the ability to create some joy along the way is extraordinary. It is all reflected in the results of our staff survey which places us really well in comparison to other similar organisations and amongst the best nationally in many dimensions. The latest national 360° survey, through which other bodies outside the organisation articulate their view of our capability, similarly demonstrates a really positive sense of our approach and impact. Again we stand comparison with the best nationally. None of this could be possible without the people, and without the values and commitment that they bring to their work. When you boil things down, we only really have three things; our relationships, our word and our choices. I believe this to be as true for organisations as I believe it to be true for us as individuals.

Some great things have happened in Calderdale this year. The opening of the Piece Hall following its beautifully judged renovation has been for me a symbol of the energy and positivity that I am feeling around this place at the moment. Something that we already had has been renewed and made relevant. It is drawing interest from around the world. It is, in a sense, an example that we can follow in our thinking about health and care. This year sees is the 70th Anniversary of the creation of the NHS. Those of us who work within the service are proud to be

part of it. There is a nobility to the concept which remains the envy of the world. But like the Piece Hall, it cannot stand still. It needs to adapt and change so that it remains relevant and responsive to the changing times. I want to recognise the work that has been done within the local authority which has landed us in a place where each of the statutory organisations in health and care in Calderdale have signed up to the approach we are naming 'Calderdale Cares' which I believe to be fundamentally important, and paves the way for a whole system to adopt new approaches and new sorts of relationships in pursuit of this endeavour – to renew and refresh the way in which health is improved and in which health and care services are delivered. Building from what we have already got something better and relevant to the world as it is, and which belongs to the people in a tangible way. Our commitment as a CCG is that we will continue to invest in building the relationships across the system, to play our full part in that, to talk about it openly, honestly and truthfully and to invite people in to participate in the creation of it, and to be clear about the choices open to us and the opportunities and risks as we see them.

A change like the change that we consulted upon two years ago is inevitable. The forces that we knew then would make the need for that change are acting now. This recent winter is a demonstration of that fact. Whilst we cannot yet build our new hospitals, the work that we have done in response to winter, by bringing health and care teams together and working in partnership, is our response to the impossible task set for us by government.

Dr Matt Walsh,
Chief Officer

As incoming Chair of the Governing Body, I would like to take this opportunity to thank Dr Matt Walsh and every member of the CCG's staff for their tremendously hard work in achieving the year-end position that Matt has described above. Obviously this is not a time for complacency and the coming year will be every bit as challenging for the CCG and our partners and stakeholders.

Finally, this year's Annual Report would be incomplete if it did not include a mention about Dr Alan Brook who retired from the CCG at the end of April. Alan has been the Chair of the Governing Body since the CCG was established in 2013 and his contribution to the life and work of the CCG, and its successes as an organisation, has been huge. A steadfast and courageous partner in leadership, he has withstood the challenges and the personal and sometimes hurtful criticism with patience and good humour, helping the CCG and the whole system along the way.

We would like to take this opportunity to place on record our thanks and those of the Governing Body and the wider NHS for his example and for his big heart.

Dr Steven Cleasby
Chair

Performance Report

Performance overview

1. Performance of the CCG during 2017-18

This section provides a summary of the purpose and activities of the CCG, how we have performed during the year and any key risks to the achievement of our strategic objectives.

Our health and care system locally has seen and will continue to see unprecedented challenges. We have therefore embarked on large-scale system change to meet the triple aim of improving health, quality and efficiency. Our plans are focused on proposals relating to hospital service change, plans to transform and integrate community services and the need to strengthen prevention, self-care, and personalisation. Later in this performance report we talk about the work that we are carrying out with partners at Calderdale Council, our main providers and the voluntary sector to achieve those aims.

We have worked hard with our colleagues across West Yorkshire to ensure urgent and emergency care resilience. One of our key areas of focus has been on reducing delayed transfers of care. The collaborative working across health and social care has resulted in Calderdale being one of the best performers in the country. We have maintained a close grip on performance against the NHS Constitution Standards and the Better Care Fund Targets and this focus is reflected in the overall achievement of those targets.

The health and social care system continues to be under significant financial pressure in both Calderdale and across the country. At the CCG, we have a clear understanding of the scale of the challenge and one of our key priorities during the year has been financial recovery.

To be clear however, there are some lines that we will not cross. Whilst we have been looking at every line of our spend to deliver value and have engaged with our partners on an agreed way forward to achieve system financial recovery, we have worked hard to ensure that the impact of any proposal is fully assessed. We have taken account of the need to maintain quality and safety; address inequalities and protect the interests of the most vulnerable in our society. For example we are committed to meeting the Mental Health Investment Standard which guarantees investment equivalent to the uplift in the CCG's financial allocation. In all this, we have maintained our focus on our engagement with local people and on continuing to build partnership working.

Our approach to financial recovery is reflected in the achievement of £7.2m Quality, Innovative, Productivity and Prevention (QIPP) savings and the achievement of our statutory financial targets.

2. Purpose of the CCG

NHS Calderdale CCG is a membership organisation consisting of 26 general practices. Our purpose is to improve the health and lives of the estimated 220,260 people living in Calderdale and/ or registered with a Calderdale GP practice.

This is achieved by working collaboratively with our partners and stakeholders to:

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

Our overall budget allocation was £312m in 2017-18 which we used to commission health and care services in a range of areas including emergency and urgent care, hospital services, services for children and young people, mental health and learning disabilities and continuing care. The performance analysis section of this report contains further detail of our financial position and recovery plan for 2018-19.

3. Activities of the CCG in 2017-18

The CCG has worked hard this year in five key areas, to:

- Transform the way that health and care is provided;
- Keep people safe and continually improve the quality of care;
- Maintain system resilience;
- Achieve system financial recovery;
- Enhance the health and wellbeing of our staff.

We have had a full public and patient engagement programme of work, ensuring that everything we do has been informed by people who use the services, local communities and key stakeholders. We have also prioritised the working with partners across health and care to reduce inequalities and improve the outcomes for our local population. We have worked closely with our colleagues across West Yorkshire and Harrogate to take forward a programme of work to improve services that are better delivered across a wider footprint – such as cancer services.

In all this we have one over-riding ambition and that is to achieve a sustainable health and care service in which local people are able to thrive.

Further information on our performance and our key activities is provided in the Performance Analysis section below.

4. Key issues or risks

The issues and risks for the CCG reflect the pressures being experienced across Calderdale, the region and nationally.

The financial sustainability of the system and the need for a clear financial recovery programme remains one of the key challenges to our performance. This, together with the challenges to the resilience of the urgent care system, is reflected in the high level risks identified by the CCG in 2017-18 and onward for 2018-19. Other high level risks to performance relate to the sustainability of quality and safety.

Further detail on our approach to the management of those risks and a summary of the in-year risks classed as 'Serious' on our Corporate Risk Register can be found in the Governance Statement (see page 48).

The risks to the delivery of our strategic objectives and compliance with the CCG's licence are set out in a summary of the Governing Body Assurance Framework (Appendix 3 of the Governance Statement).

5. Summary of performance

Overall the performance of the CCG and the system has been good, with significant reductions in the delays being experienced by patients in the transfer of their care and the delivery of the majority of the NHS Constitution Targets. The strong picture in terms of system performance is due in part to the clear focus of the CCG on financial recovery, performance, contract management and the close monitoring of the quality of care being delivered to local people in hospital, by general practice, in the community and in care homes.

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

Performance analysis

This section provides more information on:

- How system performance is measured and monitored and how the associated risks are managed;
- Key financial and non-financial information (information on counter fraud and anti-crime activity can be found in the Governance Statement, page 70);
- The development and performance of the CCG during the year (see the Governance Statement and the key activities section of this performance analysis);

- The impact of the CCG on the environment (see section: sustainable development).

We maintain a strong grip on performance through our formal governance arrangements, with performance, contracting, financial recovery and quality and safety reports as well as quality dashboards being scrutinised through our internal governance arrangements. These reports are received at each Governing Body meeting, together with the high level risk report, which enables the Governing Body to receive the right level of assurance about the management of those risks.

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

Internally, oversight is provided by the Senior Management Team and operational groups such as the Commissioning Primary Medical Services Committee operational group and the Recovery Operational Group.

Further information about the operation and activities of the CCG's Governing Body and Committees as well as the Integrated Risk Management Framework is contained in the Governance Statement (see page 48).

➢ Partnership working

Good partnership working is key to achieving a sustainable health and care service in which local people and staff are able to thrive. This year we have moved into a new gear in terms of our partnership relationships and collaborative working. We have:

- Continued to develop our thinking about new models of care and new ways of working through the Health and Wellbeing Board – as set out in the Single Plan for Calderdale and Calderdale Council's place based response, *Calderdale Cares*.
- Developed our thinking with the practice commissioning leads and commissioning engagement teams and supported the development of new initiatives to improve care being delivered for local people – such as improved access to general practice and primary care home.
- Worked with colleagues at West Yorkshire and Harrogate Health and Care Partnership to develop a programme of work that would be better delivered over a larger footprint – such as Stroke Services.
- Continued strong partnership working through Local Safeguarding children and Adults Board and strengthened CCG input into the Community Safety Partnership.

6. Key performance indicators used by the CCG

The CCG uses a number of key performance indicators to measure and manage performance across the system. These include the NHS Constitution Standards, Quality Premiums and

Better Care Fund Targets. We report on progress against the requirements of the Improvement and Assessment Framework through our internal governance arrangements.

Further performance information is provided through the quality dashboards for the main commissioned providers, patient experience, patient engagement activity, complaints and incident reporting and monitoring of national and local Commissioning for Quality and Innovation Schemes (CQUINS). This data provides the CCG with a comprehensive view of the performance and pressures being faced by the local health and care system.

- **NHS Constitution standards**

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

Performance against the standards of the NHS Constitution has been strong throughout the year with the majority of the constitutional standards being achieved (See appendix 1: Performance Report, page 37).

Sustaining the 4 hour target in Accident & Emergency continues to prove challenging for our system, with periods of underperformance during the year. Whilst the position compares favourably with the reported performance across the region and nationally, it remains below the NHS Constitutional Standard. This is reflected in its critical risk status and the close scrutiny by our Finance and Performance Committee, with action being taken forward through the A&E Delivery Board.

*Yorkshire Ambulance Services (YAS) are participating in the NHS England led Ambulance response Programme (ARP – phase 3). This commenced on 1st September 2017 and will focus on regional updates until further agreement at national level.

- **Quality Premiums**

The Quality Premium is an NHS England scheme to reward CCGs for improvements in the quality of services they commission. The Quality Premium paid to CCGs in 2017-18 reflects the quality of the health services commissioned in the previous year. The measures cover a combination of national and local priorities, the financial reward available and the achievement in Calderdale.

The total reward available to the CCG was £1.0m. Pressures associated with delivery of the financial plan made the CCG ineligible via the Finance Gateway to access any Quality Premium reward money. For the purposes of clarity, this had no impact on the CCG's underlying financial position as the CCG had not made an assumption about the award of the quality premium in its financial plans for 2017-18.

➢ Better Care Fund

The Better Care Fund is a national initiative to promote integrated out of hospital care and is seen as an important enabler for system transformation and integrated commissioning. The two national conditions introduced in 2016-17 continue to be a focus for the effective delivery of out of hospital services and reductions in delayed transfers of care, both of which have clear alignment with the delivery of the Single Plan for Calderdale. 2017 saw the approval of the Health and Wellbeing Board's BCF Plan for 2017-2019 (with revised targets for Delayed Transfer of Care set by NHS England). The revised targets have proved challenging for all partners, but through close collaboration, marked improvements have been made towards achieving the targets.

The Better Care Fund has four main indicators against which we measure our performance:

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

Performance is monitored through the A&E Delivery Board, the Integrated Commissioning Executive on behalf of the Health and Wellbeing Board and to the CCG's Finance and Performance Committee. *(*See appendix 2: Performance Report*).*

Delayed Transfer of Care

The CCG, with its partners, has placed a high priority on reducing delays in transfers of care. Excessive and often unnecessary delays in discharging people from hospital care can have a significant impact on their health and wellbeing. We know that, particularly for elderly patients, these delays result in poor outcomes and delay recovery.

Close partnership working has resulted in different agencies: using the paperwork and assessments undertaken by other professionals to avoid duplication and speed up the discharge process; training with frontline staff; a revised discharge policy and protocol relating to housing (including people who are homeless); a non-weight bearing pathway and a significant increase in social care packages of care to support people in their own homes.

➢ *System financial recovery/Quality, Innovation, Productivity and Prevention*

We have built on the work carried out over the past 3 years, by working on a set of initiatives which seek to improve patient care and reduce inefficiencies. The key QIPP (Quality, Innovation, Productivity and Prevention) initiatives that we have been focussing on during the year include:

- Quest for Quality in Care Homes
- Reducing delays in transfers of care
- Rehabilitation and community beds
- Continuing healthcare
- Frailty and falls
- Community based Pain Service to deliver rehabilitation for patients with persistent pain.

Whilst we acknowledge that we will have to make some very difficult decisions, we have worked hard to ensure that decisions we make as part of our recovery programme support our overall strategic direction to:

Musculoskeletal (MSK) services

A new *First Point of Contact* service for MSK conditions was launched in June 2017. This has led to more patients being successfully managed in the community, reducing the number of people being referred unnecessarily into hospital. The added benefit of this is that waiting times for patients needing a referral for surgery have reduced.

There has been good feedback about the service expansion.

- Deliver more care close to home;
- Develop new and innovative ways of delivering care;
- Empower and support independence;
- Develop the capacity and capability of the voluntary and third sector;
- Take account of the impact on our most vulnerable populations, in all of our decisions.

7. Key activities of the CCG

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

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

7.1 Transform the way that health and care is provided

Our plans are focused on proposals relating to hospital service change, plans to transform and integrate community services and the need to strengthen; prevention, self-care, and personalisation, delivering new models of primary and community services and working across the wider West Yorkshire Footprint.

➢ Hospital service change

The main focus in relation to proposed future arrangements for hospital and community health services was Calderdale and Huddersfield Foundation Trust's (CHFT) production of the Full Business Case and the associated documents by Calderdale and Greater Huddersfield CCGs. CHFT's Full Business Case was approved by its Board in August and submitted to NHS Improvement, for assessment. In order to provide further assurance on the proposals, the CCGs further developed the work in relation to Quality and Safety, travel and transport and activity modelling on the proposed move of services from a hospital to a community setting.

This supporting information, together with the assurance provided by an independently chaired Travel and Transport Group, and the detailed work on financial affordability and system financial sustainability was presented to the two Governing Bodies in October in relation to CHFT's Full Business Case. Each CCG applied three considerations in its decision making:

- Is the Full Business Case in line with the model on which we consulted?
- Is the Full Business Case affordable to commissioners?
- Does the Full Business Case improve and achieve the financial sustainability of the Calderdale and Greater Huddersfield system of care?

Both CCGs agreed to indicate their support for the Full Business Case to NHS England.

The independent Chair of the Travel and Transport Working Group published his report in February, 2018.

In March 2018; the Independent Reconfiguration Panel submitted its report to the Secretary of State for Health following the Joint Health Overview and Scrutiny Committee's decision in July, 2017 to exercise its right to refer the proposals to the Secretary of State for Health and an

application for Judicial Review was upheld. The Secretary of State has considered the report from the Independent Reconfiguration Panel and advised that further action is required before a final decision is made about the future arrangements for hospital and community health services in Calderdale and Greater Huddersfield.

➢ Integrating commissioning

The CCG and Calderdale Council have a long history of joint working. Our work with Calderdale Council focuses on delivery of five key outcomes:

- Reducing inequalities and improving health outcomes (including equality/social cohesion, financial inclusion, attainment levels);
- Ensuring economic growth (job and skills);
- Building a sustainable future (environment and sustainability);
- Improving the quality of care and experience;
- Improving value and efficiency.

Our CCG has worked with partners on the Health and Well-being Board to set out our strategic intent for Calderdale. This is described in the Single Plan for Calderdale. Over time, we aim to bring together planning for tackling the broader determinants of health and well-being - to improve the lives of the people in Calderdale. The work provides an opportunity to develop an integrated commissioning approach that supports the development of new care models in Calderdale as well as new commissioning arrangements that span the West Yorkshire and Harrogate footprint.

Focus on Frailty and reducing falls

An unnecessary hospital stay for an elderly person can result in deconditioning very quickly; this reduces both life expectancy and quality of life. Work on improving care for frail elderly people both in hospital and in primary and social care links to our work on reducing delayed transfers of care and has included:

- Introduction of the electronic frailty index in primary care which has improved the identification of our most severely frail elderly people.
- GP assessment with a falls assessment to ensure patients are receiving the right treatment and care; management of long term conditions, medication review.
- Referrals to other services as appropriate.
- Introduction of the A&E frailty team to undertake rapid assessment of frail, mainly elderly patients and where possible avoid unnecessary and harmful admission to hospital.
- The frailty team work closely with social care and therapy teams to ensure the person is fully supported once assessed as not requiring an inpatient stay.
- Improved pathways at CHFT for people who have fallen and broken a bone have resulted in a significant reduction in length of stay for this cohort of patients.

Further information on the way in which we work with partners on integrated commissioning and tackling the wider determinants of health can be found on page 34 (Complying with our statutory duties). One example of the partnership work we are taking forward is in Children and Young People's Emotional Health and Wellbeing.

Children and Young People's emotional health and wellbeing

We are committed to improving the emotional health and wellbeing of children and young people in Calderdale, through building resilience, providing early intervention and ensuring appropriate treatment for more complex emotional health and wellbeing needs.

Kooth.com is a new Calderdale-Based, online counselling service, for young people aged 11-25 years. It offers free, safe, confidential and non-stigmatised way for young people to access support.

The service was launched in June 2017 and reports show a good uptake of the service.

Schools across Calderdale have been promoting and raising the awareness of this service to all pupils.

Children, young people and their families are at the heart of all aspects of this work and input from these key stakeholders is integral to our approach to transformation. Young people play a fundamental part in the implementation of our Local Transformation Plan (LTP) priorities as well as being part of the decision making process each year - setting priorities on spending.

Child and Adolescent Mental Health Services (CAMHS)

Over the past year we have worked to get a better understanding of the current needs, demands and delivery of the Child and Adolescent Mental Health Services (CAMHS). We have held a variety of engagement events and discussions with neighbouring localities. As a result we are developing an all-encompassing service framework, which is person-centred and functions as a whole system.

➢ New models of working in primary care

Calderdale CCG's practices have been active this year in developing new ways of working in order to improve access to services (particularly during the winter) and the care delivered for patients. Some of these areas are highlighted below:

General Practice Forward View

We continue to build on our ambition and vision for primary medical services in Calderdale to 2020.

This year the CCG launched GP Services situated in 'Hub' locations across Calderdale; these offer access to planned general medical services appointments from 6:30 pm to 8:00 pm, Monday to Friday. We currently have hubs located in Halifax Central, South Halifax and North Halifax and a further roll out to cover the whole of

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

Calderdale in 2018-19.

Eight Practices have attended training to be able to actively sign post patients to a variety of local services for the support and management of their condition or presenting problem. Additionally, 20 Practices have received training in the management of Practice Correspondence, developing new processes and ways of working that will support the release of clinician time in the practice. All the practices in Calderdale will have received this training by the end of 2018-19.

Good access to general practice

We have made significant progress in improving access to primary medical services this year. The introduction of a General Practice Access Incentive Scheme - which was informed by our engagement activity - has seen a significant improvement in patient access, with practices opening from 8 am to 6:30 pm Monday to Friday and as a minimum offers 70 appointments per 1,000 registered patients per week.

In order to test new ways of working, the CCG together with NHS England, have piloted a new GP telephone consultation service model. This was tested with 8 of our GP practices over 6 months. The learning from the pilot will support our future plans for improved access.

As part of our system resilience work, the CCG invested in a scheme to support practices in offering an additional 17,029 planned appointments over the winter period.

We also took a considerable step forward in collaborative working between primary and secondary care, this year. Accident & Emergency (A&E) staff are now able to make an appointment for patients attending A&E, to be seen at their own GP Practice, if it is considered clinically appropriate.

Primary Care Home

Practices Managers, clinical leads, and colleagues from Health and Social Care came together in December to hear the National Association of Primary Care talk about Primary Care Home. Primary Care Home is an innovative approach to strengthening and redesigning primary care. The model brings together a range of health and social care professionals to enhance personalised and preventative care for the local community. Four key characteristics make up a primary care home:

- an integrated workforce, with a strong focus on partnerships spanning primary, secondary and social care;
- a combined focus on personalisation of care with improvements in population health outcomes;
- aligned clinical and financial drivers through a unified, capitated budget with appropriate shared risks and rewards; and
- Provision of care to a defined, registered population of between 30,000 and 50,000.

Medicines Management

The CCG's Medicines Management team (MMT) works with our member practices who are also supported by a practice pharmacy team, to get the maximum benefit for patients from the money spent on prescribed medicines and to deliver efficiency savings whilst maintaining high quality care for patients. The CCG is forecast to spend less than the allocated prescribing budget for 2017-18 which releases money to be used elsewhere for patient care.

The team also works with other CCGs and providers on the South West Yorkshire Area Prescribing Committee as well as other groups such as the Medicines Safety Group.

The benefits for patients from this shared working, is a consistent approach to prescribing across the area. The MMT have introduced several new local schemes in 2017-18 to improve quality, safety and cost effectiveness in prescribing, including *Optimise Rx* and changing the way prescriptions are ordered.

Optimise Rx

The Optimise Rx software went live across Calderdale in August 2017. This prescribing tool is now in all the Calderdale practices and promotes quality and safety in prescribing as well as cost effective prescribing. As a result, a significant numbers of safety and best practice messages have been actioned. These include:

- **Penicillin**: not recommended in patients with a history of an adverse reaction to penicillin.
- **Nitrofurantoin**: contra-indicated in patients with severe renal impairment.
- **Trimethoprim**: concomitant use with methotrexate is strongly discouraged. This alert is invaluable as co-prescribing of these medicines can be fatal.

In addition, the software has accrued efficiency savings of over £60,000 in 2017-18.

➢ Working across the wider West Yorkshire footprint

We are working together with the other CCGs, hospital Trusts, local councils, police, fire and rescue, Healthwatch and the voluntary and community sector as part of the West Yorkshire and Harrogate Health and Care Partnership. Our aim is to address the health and well-being gap and bring about the changes needed to improve services, the health and care of the estimated 2.6 million people who live in the region.

The CCG's Chair and Chief Officer are active members of the West Yorkshire and Harrogate Joint Committee of CCGs. The high level plan includes work being taken forward in a number of areas:

Cancer: Workstreams on tobacco control, early diagnosis, developing high quality services, patient experience and living with and beyond cancer. This work is aligned with other Health and Care Partnership programmes, including support for healthier lifestyle choices.

Stroke: aims to improve stroke outcomes, use resources efficiently and effectively and ensure that stroke services are sustainable and fit for the future.

Elective care/standardisation of commissioning policies: aims to improve health by better prevention and supporting healthier choices. This will reduce variation, inconsistency and has the potential to generate efficiency savings.

Mental health: aims to reduce variation, develop consistent pathways, support providers to achieve the best standards and achieve economies of scale. Areas of focus include emergency care, specialist Child and Adolescent Mental Health Services (CAMHS) and autism services, with supporting people in crisis, closer to home a key aim.

Urgent and emergency care: aims to ensure that people get the right care, in the right place at the right time.

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

Further information on the Joint Committee of CCGs can be found in the Governance Statement on page 56.

7.2 Keeping people safe and improving quality of care

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

- Maintaining close working relationships with our providers through, for example, attendance at Quality Boards.
- Conducting patient safety walkabouts to our main providers to gain assurance of the quality and safety of services.
- Where care homes have been failing, we have worked with partners to ensure safe delivery of care for clients and sustainability of the sector.
- Maintaining a rigorous grip on quality performance through the scrutiny of the quality and safety dashboards.
- Encouraging member practices to report clinical and other incidents in order to improve the way services are provided.
- Developed our approach to monitoring quality and safety in primary care. Where concerns have been raised, we have adopted the NHS England Quality Assurance Process.
- Strengthened our approach to Quality Impact Assessments.

Approach to Quality Impact Assessments

Quality Impact Assessments (QIAs) have been developed to ensure that the CCG has the appropriate processes in place to safeguard the quality of care for patients when proposing a change in service or developing a business plan and to identify any possible impacts as a result.

This is a continuous process and enables appropriate decision making by considering the indicators of Patient Safety, Clinical Effectiveness, Patient Experience, and workforce.

Some of examples of our work are:

Sign up to Safety

Sign up to Safety is a national initiative to help NHS organisations and their staff, achieve their patient safety aspirations and enable them to care for their patients in the safest way possible. Conversation is a powerful thing and when done in the right way, can lay the foundations for a strong safety culture. In 2017, a number of different approaches were used to enable people to talk about keeping people safer.

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) has been part of the national Sign up to Safety campaign since 2015, and is reducing avoidable harm in five main areas: *reducing the frequency of inpatient falls and new pressure ulcers; reducing unintended missed doses of medicines; reduce harm (moderate and above) in incidents that resulted in restraint; reduce the use of prone restraint and the during of prone restraint.* The Patient Safety Strategy Group which monitors progress has seen reductions in avoidable harm, which have exceeded the original targets in all areas except medicines omissons, where good prgress has been made.

Quality Improvement – Healthcare associated infections

Gram-Negative Bloodstream Infections (GNBSIs) are believed to have contributed to approximately 5,500 NHS patient deaths in 2015 and E.coli (Eschericia coli) is one of the largest of these infection groups. During the year, the Secretary of State for Health launched an important ambition to reduce healthcare-associated GNBSIs by 50%, by 2021 and also to reduce inappropriate antimicrobial prescribing by 50% by 2021.

The CCGs in Calderdale, Greater Huddersfield and North kirklees have worked with the Infection, Prevention and Control (IPC) Team to develop a means of automatically extracting the data from clinical systems in primary care. This supports the IPC Team to undertake high quality post infection reviews – helping to generate understanding about the causes of E.coli BSIs.

Nursing Associate Work

The new Nursing Associate role sits alongside existing healthcare support workers and fully-qualified registered nurses to deliver hands-on care for patients. The aim is to ensure that the staff of the future are able to deliver the high quality care patients need irrespective of care setting. Nursing Associates will work across health and social care and have experience of multiple different care settings. This role will create a career pathway that offers development opportunities and job satisfaction to those who want to progress in the nursing profession. The Calderdale, Kirklees and Wakefield Partnership pilot (CKW) is part of the 'fast follower' test site group which has 23 trainees currently on the programme who will qualify in 2019. The trainees cover health and social care and include backgrounds in adult, learning disabilities and mental health. These backgrounds enrich the learning and provide a foundation of how we are building our workforce for the future.

The planning for the new CKW apprenticeship programme for the nursing associate is underway with Huddersfield University. More providers are joining the partnership including a strong presence of acute, community, NHS and non NHS providers to bring this apprenticeship to fruition in June 2018.

Further information on the work of the Quality Committee can be found in the Governance Statement (see page 53)

Further information on how we have complied with our statutory quality duties can be found on page 31.

- **Safeguarding Adults and Children**

The CCG has a legal responsibility to ensure that the needs of children and adults at risk of abuse or suffering abuse are addressed in all the work that we undertake and commission on behalf of the people of Calderdale.

The CCG's safeguarding team works to ensure that the safeguarding arrangements across Calderdale and collaborative working with partner agencies both locally and nationally are robust and fit for purpose. As part of this we seek assurance that the services we commission have effective safeguarding arrangements in place, to ensure that children and adults at risk receive safe care of the highest possible standard.

Throughout the year, the team has continued to support and manage the expanding field of safeguarding including the Prevent agenda, human trafficking and modern slavery, child sexual exploitation, forced marriage, domestic abuse and female genital mutilation.

This has included:

- **Raising the profile, particularly in general practice**, of safeguarding adults, Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS), Prevent, domestic violence and abuse. This has led to an increase in the numbers of health staff accessing Prevent training. The training helps practitioners to safeguard people at risk from being radicalised to support terrorism or becoming terrorists themselves.

- **Further development of safeguarding in primary care** by facilitating quarterly peer support meetings with safeguarding lead GPs, supporting the introduction and revision of safeguarding policies for general practice; using the Adults and Children's Safeguarding Self-Assessment tool to assess the safeguarding systems and processes in place in general practice.

- **Revised CCG training strategy and training programme** in preparation for the forthcoming NHS England Safeguarding Adults: Roles and Competences for Health Care Staff – Intercollegiate Document.

- **Developing an IT system compatible template** to allow health and care staff to flag patients' electronic records where there are safeguarding and domestic abuse concerns.

- **Ensuring systems are in place for Deprivation of Liberty (DoL) applications** to be made to the Court of Protection for people whose care in their own homes and supported living is particularly restrictive.

The team makes significant contributions to the work of the Calderdale Safeguarding Children Board and Safeguarding Adults Board. This will continue into 2018-19 through its work with key partners to review the safeguarding children's board arrangements following the publication of the *2018 Working Together to Safeguard Children* and with GPs to further improve child protection reporting. The team will also continue to provide safeguarding input into major CCG programmes of work such as reducing hospital admissions and de-conditioning in hospitals.

7.3 Ensure system resilience

The Accident and Emergency Delivery Board plays a key role in ensuring regular dialogue between the CCG, primary and secondary care, social care, the voluntary sector, Healthwatch and Community Pharmacy West Yorkshire in order to maintain good system resilience. Meeting monthly, the Board keeps under review system performance and identifies mitigating actions. As part of this, it oversees and seeks assurance on emergency and business continuity planning, including winter planning. The Board also:

- Identifies risk to the delivery of high quality and responsive services and develops responses within financial and workforce constraints;
- Ensures alignment with the work of the West Yorkshire and Harrogate Emergency and Urgent Care Network and the work of the Health and Care Programme;
- Provides an opportunity for partners to come together in development mode to resolve issues and nurture innovation.

The four key priorities for the Board are set out in its delivery plan (2017-2019). These are:

- Reducing transfer of care delays and harm caused through deconditioning;
- Support capacity and capability building in care home and home care markets
- Reducing current high agency spend;
- Improving access across the 7 day period, including improving access to primary care.

7.4 Financial performance and system financial recovery

➢ Financial Performance

The CCG has had a challenging financial year in 2017-18. The financial plan for the year was to draw down £3.1m of the CCG's accumulated surplus leaving an overall surplus balance of £2.6m, which was less than the NHS England planning requirement of maintaining a cumulative 1% surplus. In addition the CCG had a very challenging QIPP target of £11.5m which was 3.7% of our budget for purchasing healthcare services for the population. The scale of the challenge is in part due to the financial pressures brought forward from 2016-17; the CCG's requirement to contribute 0.5% to a national risk reserve and also that Calderdale CCG continues to receive the lowest levels of growth in allocations across the region. As the financial plan did not meet

the NHS England planning requirements, the CCG was not eligible for achieving any Quality Premium payments as our underlying surplus was less than 1% of our allocation.

I am pleased to say that the CCG has been able to deliver its financial plan for 2017-18, despite the financial challenges. The CCG was successfully able to deliver £7.2m QIPP savings however the shortfall against the planned £11.5m savings caused a financial pressure during the year. In addition the CCG experienced unprecedented cost pressures in prescribed medicines due to national stock shortages which led to temporary price increases. The CCG was able to mitigate these pressures during the year through use of the CCG's contingency; utilising underspends on acute contracts and also regrettably through stopping non-recurrent investments.

The CCG has a number of statutory financial duties and targets against which our performance is monitored. Although the CCG has experienced significant financial challenges, I am pleased to be able to report that we have met all our statutory financial duties. The CCG has underspent against our running cost allowance of £4.7m, by £192k (2017-18).

As set out in the 2017-18 NHS Planning Guidance; CCGs were required to hold a 0.5 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

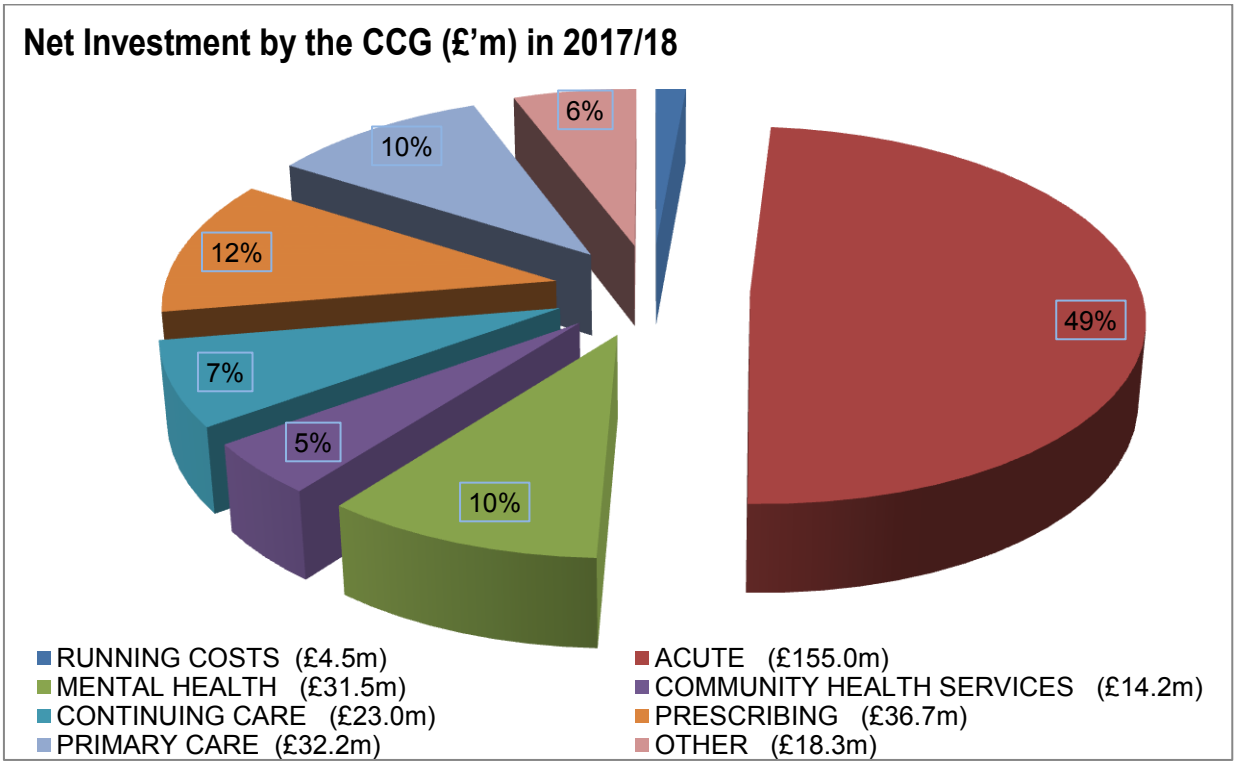
In the event, the national position across the provider sector has been such that NHS England has been unable to allow the CCGs' 0.5% non-recurrent monies to be spent. Therefore, to comply with this requirement, our CCG has released its 0.5% reserve to the bottom line, resulting in an additional surplus for the year of £1.5m. This additional surplus has been added to our brought forward surplus meaning the CCG has a cumulative surplus balance of £4.5m which will be carried forward for drawdown in future years.

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

Financial Duty	Achieved / Not Achieved	Performance in 2017-18
Achieve operational financial balance	**Achieved**	Delivered surplus of £4,552k
Revenue administration resource use does not exceed the amount specified in Directions	**Achieved**	The CCG underspend on its administration by £192k
Maintain capital expenditure within Capital Resources	**Achieved**	The CCG did not receive any capital resources in 2017/18
Manage cash within the CCG's Cash Limit	**Achieved**	Cash balance of £83k
Better Payment Practice Code - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty)	**Achieved**	Non-NHS invoices 99.52% volume, 98.89% value. NHS Invoices 98.36% volume, 99.99% value.

➢ Investments in services

During 2017/18 we invested over £312m to improve the health and care of local people through the commissioning of high quality services. The net investments in the different sectors as well as the proportion of spend against the CCG's management cost allowance is set out in the diagram below.



As a result of the financial pressures the CCG has not been able to utilise non recurrent budgets to invest in specific services as in previous years. However we have maintained investments in priority areas, such as care closer to home, children and young people's emotional health and wellbeing, adult mental health services.

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

➢ Financial planning for 2018-19

The plan for 2018-19 is extremely challenging and relies on the CCG being able to make significant levels of QIPP savings of £7.1m, which is over 2% of our programme allocation. This plan is an in-year breakeven plan against the resource allocation that we will receive from NHS England. This is an improvement compared to 2017-18, where the CCG planned to spend some of its cumulative surplus during the year meaning that the CCG was classed as having an in-year deficit in 2017-18. NHS England planning assumption in 2018-19 is for the CCG to breakeven, so we are planning to meet the NHS England expectations for Calderdale CCG. This means that the CCG may be able to qualify for Quality Premium payments in 2018-19.

The CCG has included a number of reserves within our financial plan for 2018-19 which reflect NHS England guidance, these include:

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

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

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

The health and social care system is under significant pressure in both Calderdale and across the country. The CCG together with Greater Huddersfield CCG and CHFT has established a System Recovery Group (SRG) to help deliver £16m savings to both the CCGs and to the Trust. As part of our recovery programme, the CCG will be reviewing all its previous investment and contracts to ensure value for money and that expected outcomes are being delivered. In addition, the CCG has identified five key areas to focus resource whilst in financial recovery. These are:

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

The Governing Body has agreed the financial plan for 2018-19 and recognises that the level of savings required to meet our plan is challenging. As part of any investment recognised above the Governing Body has clear expectations of how they will aid our recovery and financial sustainability as well as deliver clear outcomes for patients.

➢ **Financial Risk**

As part of our planning process the CCG has identified a number of risks that threaten delivery of our 2018-19 financial plan which are reflected on our corporate risk register (see appendix 1: Governance Statement: risks to the CCG), these include:

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

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

- Investments are only committed if there is robust assurance that they are affordable and aid financial recovery/sustainability;

- Opportunities for disinvestment and reinvestment in healthcare are identified and realised, to improve outcomes and ensure that the money is directed where it can do most good; and

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

Sustainable Development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities for which we commission and procure healthcare services. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Spending money well and considering the social and environmental impacts is enshrined in the Public Services (Social Value) Act (2012).

In order to fulfil our responsibilities we produced a Sustainable Development Management Plan (SDMP) in 2015.

➢ Good Corporate Citizenship Tool

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

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

Encouraging a healthy workforce

Encouraging and supporting workforce health and wellbeing is one of our key priorities. We have engaged in a range of initiatives to support the physical and psychological wellbeing of our staff. This has strong sponsorship from the Governing Body and the Senior Management Team, and is managed through the Staff Forum.

Some examples are:

- The provision of an Employee Assistance Programme, providing confidential support, advice and counseling to staff.
- Participation in the Global Corporate Challenge, which generates compelling evidence of the positive impact that it has on the health and wellbeing of our staff. This 100 day challenge is aimed at increasing physical activity and improving nutrition, sleep quality and psychological resilience. Key outcomes for staff in were that 65% of participants exceeded the national guidance for physical activity of 10,000 steps per day, 86% reported feeling less stressed and 64% said they felt more productive;

Volunteering

The CCG working in partnership with Voluntary Action Calderdale encourages and supports its staff to become involved in volunteering activities. Volunteering has been proven not only to benefit the community but also greatly benefit staff.

In December, staff:

- Helped organise a Christmas party for an elderly care home as part of a Molly and Bill project;
- Supported the Rotary Club in packing shoe boxes containing household items for disadvantaged families

Activities planned:

- Reading to care home residents in central Halifax who suffer from Dementia
- Helping build raised flower beds at a community centre in north Halifax which will allow better accessibility for wheel chair users.

- A regular informal “tea and talk” session to encourage positive relationships across the organisation, with a regular focus on promoting positive mental health;
- The provision of a Wellbeing Half Hour, which provides staff with a weekly opportunity to undertake activities, with an overall aim of contributing to overall wellbeing and benefitting productivity;
- Training for managers in how to manage sickness absence, including the promotion of positive health and wellbeing;
- The establishment of a “walk and talk” walking group, to encourage staff to take a break, participate in physical activity, and build relationships;
- Regular mindfulness sessions;
- Blood pressure monitoring and healthy weight sessions;
- A staff volunteering programme, to benefit the local community and support staff in continuing to develop understanding of our communities.

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

➢ **Reducing our carbon footprint**

Whilst we recognise that reducing our carbon footprint continues to be a challenge for the CCG, we have maintained our focus in the following areas in order to reduce our impact on the environment:

Focus on a recycling

Over the past year we have introduced recycling of plastic, tins and cardboard in the staff kitchen, together with a food recycling bin to take away compostable foods.

The NHS sustainability day this year asked staff and visitors “what can we do to live and work sustainably?” The focus of responses was on reducing the use of plastic – particularly single use plastic, with staff generating many ideas that we will put into practice.

Recycling

1 recycled can saves enough energy to power a TV for 3 hours

1 recycled glass bottle saves enough energy to power a computer for 25 minutes

1 recycled plastic bottle saves enough energy to power a 60 watt light bulb for 3 hours

Recycled paper uses 70% less energy compared with using raw materials

Focus on reducing car journeys

Many of our staff are in shared roles, working across two or more CCGs. This increases the pressure to make regular car journeys between offices. However in 2017-18 we saved 3,794 additional Business Miles through car sharing. If travelled independently these miles would have resulted in an additional 1.3 tCO2 of emissions.

We are making much greater use of video and teleconferencing facilities at the CCG in order to contribute to a reduction in our carbon footprint. This approach reduces the need to travel, releases capacity, improves staff well-being and makes an important contribution to our financial sustainability. In 2017-18 a total of 91 video conferences were held involving an average of three people on each occasion from Calderdale CCG.

Resource usage in 2017-18

Resource	Quantity (kWh)		tCO2 emissions		Cost (Inc. VAT) (£)	
	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18
Gas	37,600	36,170	8	8	1,828	1,713
Electricity	51,652	51,109	27	23	7,265	9,103
Water (note 1)	--	--	--	--	--	--
General waste (note 2)	--	--	--	--	--	--
Recycling (including confidential waste)	--	--	--	--	2,364	2,191
	Kg	Kg			Kg	Kg
Composting (Kitchen Waste)	--	68	--	--	--	0
	Miles				Miles	
Business Travel	56,732	57,605	20.5	20.5	33,844	31,606
Business Travel – Car Share	-	3,794	-	0	-	190

Note 1: The charge for water usage is contained within the general service charge and is not separated out

Note 2: General waste disposal forms part of the cleaning contract and is not separated out.

Meeting our statutory duties

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

1. Ensuring the continuous improvement in quality (Section 14R, NHS Act 2006 as amended)

Ensuring patient safety and improving quality is core to the role of the CCG. We work hard to maintain strong relationships with our providers and this enables us to take forward the learning from reviews such as the national guidance on learning from deaths. We have worked with providers to ensure robust systems in place for mortality reviews and gained assurance through the Quality Boards.

Our focus on reducing harm, improving effectiveness and experience throughout the year has included:

- Participation in the learning disabilities mortality review LeDeR programme.
- Work with other CCGs to begin to develop ways to improve the early recognition of Sepsis across healthcare.
- Participation in campaigns such as *National Kitchen Table Week* – using this to have a conversation about Sepsis;
- Using patient experience data collected through our patient story process and Patient Experience Group, to help inform commissioning decisions and make improvements in partnership with our providers

Further information on our activity over the year on keeping people safe and improving quality can be found on page 20 above.

Serious Incidents and never events

No never events have been reported for 2017-18. We continue to work with Calderdale and Huddersfield NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust on an improvement strategy on learning from serious incidents.

The number of CCG serious incidents and never events reported in 2017-18 are contained in the Governance Statement (page 43).

Performance rating

The 2017-18 year-end assessment for our CCG will be available at www.nhs.uk/service-search/performance/search from July 2018.

2. Engaging people and communities (section 14Z2 of the NHS Act 2006 (as amended))

The Public and Patient Involvement and Experience Strategy sets out the CCG's commitment and approach to involving local people. The Strategy also sets out how we discharge our duty to involve the public (individuals and communities) in commissioning activities and the impact that the engagement activity has had. This includes the designing, planning, decision-making and proposals for change that will impact on individuals or groups and how health services are provided to them. The strategy also sets out how we discharge our duties under the under the Equality Act 2010 and the NHS Constitution.

Whilst we have produced a separate engagement annual report which contains detail on how we have involved people throughout the year, we have highlighted some of the key engagement and consultation activity below.

A copy of the Public and Patient Involvement and Experience Strategy can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/wp-content/uploads/2016/06/FINAL-refresh-2017-PPEE_strategy_v08b-Calderdale.pdf .

A copy of our engagement annual report can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/wp-content/uploads/2017/02/Annual-Statement-of-Involvement-2016-2017-FINAL.pdf

Spring 2017 – Everyone's NHS

We talked to local communities, gathering ideas about:

- How we can reduce waste and save money whilst keeping the high quality services we need.
- How we can reduce our spending on repeat prescribing.

We used different approaches to reach people including Engagement Champions, social media and a paper and online survey**.**

987 people responded and many shared ideas and suggestions on how we could reduce waste, including reducing unwanted medicines and the use of lower value medicines. They also wanted to see prescribing based on clinical effectiveness.

What we have done:

- Used the results to identify future consultation areas, helping to reduce unnecessary spending.
- Used prescribing based on clinical effectiveness as criteria for the consultation on lower value medicines.

Changing the way you order your prescriptions

Following engagement with our public as part of '*It's our NHS and we are not going to waste it'* the CCG launched a campaign in February to change the way people order repeat prescriptions in Calderdale.

This encourages most patients to order prescriptions direct from their GP rather than via the pharmacy or dispensing appliance contractor.

The aim is to reduce wastage from items being ordered when not required and avoid stockpiling of medications.

Autumn 2017 - Improved access in Primary Care

NHS England committed an additional £500 million by 2020-21 to fund additional access to GP services. This includes routine appointments for evenings and weekends to meet the needs of the local patient population.

Approaches used to reach people included GP practices and GP Patient Reference Groups, Engagement Champions, social media and a paper and online survey.

1,489 responded and told us:

- For a same day appointment the most convenient time for the majority of people (60.9%) would be 6:30 pm – 8 pm Monday to Friday;
- 67.6% said they wouldn't attend an appointment from 6:30 am to 8:00 am;
- At weekends, the most popular time for both routine (23.2%) and same day appointments (21.5%) seemed to be between 10 am-12 noon;

- What they valued most when using the GP practice and anything else they wanted the CCG to consider.

What we are doing:

The findings from this and previous engagement with the public will be used to inform the development of a specification to improve access to GP services across Calderdale. Consideration will be given to the location and facilities of any extended services. The new arrangements are due to be in place by the end of May 2018.

Autumn 2017 – Everyone's NHS

The CCG consulted on whether to continue prescribing certain branded and/or lower value medicines and products – including creams for unwanted hair, sunscreens, baby milks, and Gluten free products.

Approaches used to reach people: included Engagement Champions, patient reference groups, social media, paper and online survey**.**

1,377 people responded and told us:

- Most agreed with the proposal to stop funding some of the items;
- A lot of comments were from people who would not be affected, but felt they would be;
- That the CCG needed to prevent an impact on people on low incomes, children, young people and frail elderly people and that such individuals should be protected;
- GPs should use clinical judgement on a case by case basis;
- Needs to be more prevention, information and communication to reduce impact;
- Needs to be good communication to prevent additional worry or concern.

Self- Care campaign

The Self Care Campaign to encourage patients to consider buying their own self-care medicines went live in June. The campaign was to encourage anyone living or working in Calderdale to purchase medicines which are readily available over the counter and less expensive if they are purchased without a prescription. The campaign is ongoing and will support future work to encourage the public and patients with supported self-care.

What we have done:

The results were considered, together with clinical evidence, and informed the Governing Body's decisions about the prescribing of lower value medicines and products. A full communications pack has been produced to support GP practices and the public to understand the changes. The decision and report of findings have been shared widely with all stakeholders.

Autumn 2017 - Wheelchair Services Engagement

The current provider in partnership with the CCG and Healthwatch engaged with service users. This was as a direct result of a number of issues raised by service users, carers and families. We wrote to everyone that had used the service in the last two years and circulated a survey to key stakeholders, publicising it through Healthwatch.

287 people responded and told us:

- A number of improvements needed to be made to ensure that the current service meets the needs of all service users;
- For children and young people, carers, families and service users who have needs that change over time - timely access, good information and communication were the most reported improvements required;
- The service received more positive feedback from people who had used the service less frequently.

What we are doing:

We are using the engagement findings to inform a new service specification, which will be developed with clinicians and key stakeholders. The service provider has already identified areas of improvement from the report; including improving communications and information.

3. Reducing health inequalities (Section 14T NHS Act 2006 (as amended))

The CCG has set out within its strategic plans over the past 4 years, a clear intention to work with the local health and care partners to better integrate health and care services for the benefit of the people that we serve. We have taken this approach because when we have engaged and consulted with local people, they have been clear that we should work more effectively together to improve health and prevent illness and dependency. This intention is in line with the commitments made by Calderdale partners in the Single Plan for Calderdale, published in January 2017.

Calderdale has been selected by Sport England as one of 12 pilots to test out new work on increasing activity in our communities, particularly aimed at the inactive. This will improve health and assist in developing preventative work in line with the Single Plan for Calderdale. The work of the pilot will be overseen by the Health and Wellbeing Board

Our approach moved into the next phase when Calderdale Council made a place based proposal, known as 'Calderdale Cares'. This vision focuses on five proposed localities, builds on the formal and informal community networks that exist and seeks to develop the provision of services, based on the specific needs of each locality, thereby tackling the specific health needs of localities and reducing the health inequalities gap.

The Governing Body made a commitment in March that the CCG would work with others in Calderdale to begin to map out how this vision might be realised, including a shared commitment to reducing inequalities in both access and outcomes.

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

- Clear collaboration on the content of the Calderdale Joint Strategic Needs Assessments;
- A key focus in the Single Plan for Calderdale on tackling the wider determinants of health;
- Delivery of the Triple Aim of Improving Health, Quality and Value;
- The Council's Director of Public Health and Director of Adults and Children are advisors to the CCG's Governing Body;
- The Public Health Consultant attending our Quality Committee, the Local Medical Committee Executive and being a 'virtual' member of the Service Improvement Team to ensure that the importance of public health is visible in our plans.
- A number of joint improvement activities led by the Vanguard programme, for example the *Staying Well* initiative, which focused on reducing the negative impact of social isolation in older people, and supported self-care schemes for people with a long-term condition.

➢ **Equality and Diversity**

We are committed to ensuring that equality and diversity is a priority when planning and commissioning local healthcare. To help us do this we work closely with local communities to understand their needs and how best to commission the most appropriate services to meet those needs. Our Equality and Diversity Strategy ensures that all activity puts equality at the centre of what we do both as commissioners and employers:

- All staff and Governing Body members are required to complete their statutory and mandatory training, which includes equality and diversity.
- Establishment of the Calderdale Equality Panel (membership is drawn from a range of community and voluntary sector organisations representing each of the protected characteristics).
- The panel graded the CCG and participating NHS organisations against a set of Equality Delivery System (EDS2) outcomes to inform the Equality Objectives for 2018-2022.
- Performance against the delivery of our equality and diversity duties is reported into the Quality Committee on a quarterly basis, with the Annual Report being submitted to the Governing Body. The CCG's Public Sector Equality Duty Report 2018 can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/wp-content/uploads/2018/02/CCCG-PSED-2018-final.pdf .

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

The CCG has worked proactively with the Calderdale Health & Wellbeing Board (HWB) in the development of a single plan for Calderdale which sets out a joint strategic vision, outcomes and deliverable. This incorporated legacy actions from the original Health and Wellbeing Strategy.

This was formally agreed by the Health and Wellbeing Board in January 2017. The Board also agreed to:

- Develop an Integrated Commissioning Executive to develop and embed joint commissioning activities across the CCG and Council, in line with agreed outcomes;
- Identify a set of priority areas, which would demonstrate the value of a strengthened partnership approach;
- Adopt the recommendations in the Director of Public Health Report 2016 to promote health in the first 1000 days of life;
- Work on a set of key enabling activities which would need to be taken forward in order to deliver the strategic direction;
- Provide the basis for dialogue on developing an integrated model of community *(*based health and care services in Calderdale) which focused on the principles of prevention, supported self-care, independence, personalisation, strengthening primary care and locality working. This was described by Calderdale Council in their Calderdale Cares approach;
- Provide the opportunity to deliver on priorities developed at the State of Calderdale and Economic Resilience events held in February 18 – including a focus on youth and ensuring their important place in planning for the future, and the emotional well-being of young people

Work is ongoing to develop the metrics by which we will test delivery of the Single Plan for Calderdale. Further information on the Single Plan for Calderdale and integrated working can be found on page 16.

Dr Matt Walsh,
Accountable Officer,
24 May 2018

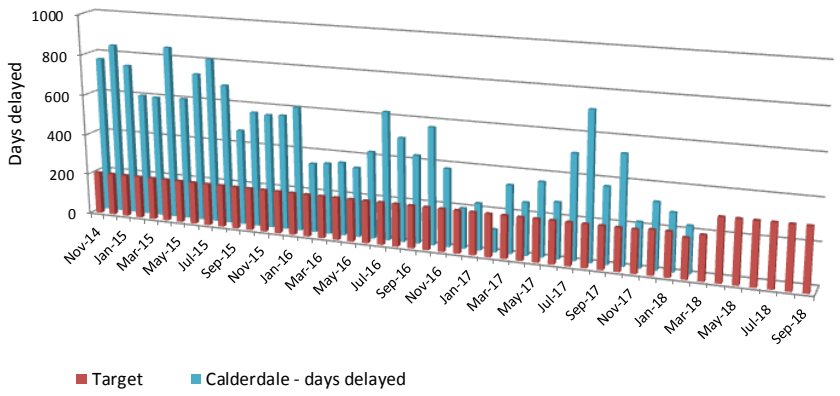
Reporting Period Mar 2017/18

NHS Constitution Rights and Pledges 2017/18

Outcome/Measure		Target Baseline	Period Actual	Period RAG	YTD	YTD RAG	Direction of Travel
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	77.7%	-	79.1%	-	
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	N/A	92.2%	-	92.8%	-	
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	93.0%		92.8%		
	Number of patients waiting more than 52 weeks	0	1		2		
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99.6%		97.2%		
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	85.3%		91.0%		
	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	93%	96.7%		94.6%		
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	97.1%		95.2%		
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	94.9%		98.7%		
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	94.1%		96.3%		
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%		100.0%		
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%		100.0%		
Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	86.0%		85.5%		
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%	100.0%	91.1%		
	Maximum 62-day wait for first definitive treatment following a consultants decision to upgrade the priority of the patient (all cancers)	tba	100.0%	tba	90.9%	tba	
Category A Ambulance Calls	Red/Category1calls resulting in an emergency response arriving within 8 minutes**						
	Amber/Category 2R calls resulting in an emergency response arriving within 19 minutes **						
	Amber/Category 2T calls resulting in an emergency response arriving within 19 minutes **						
	All handovers between ambulance and A&E must take place within 15 minutes *	95%	65.8%		61.6%		
	All crews should be ready to accept new calls within a further 15 minutes *	95%	62.1%		65.3%		

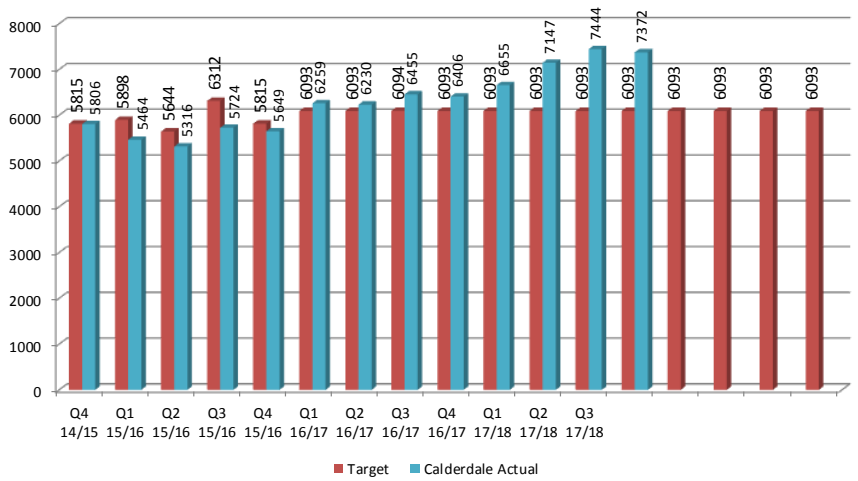
Performance against Better Care Fund Metrics (please see page 13 for further information)

DTOC - Actual days delayed by month compared to target

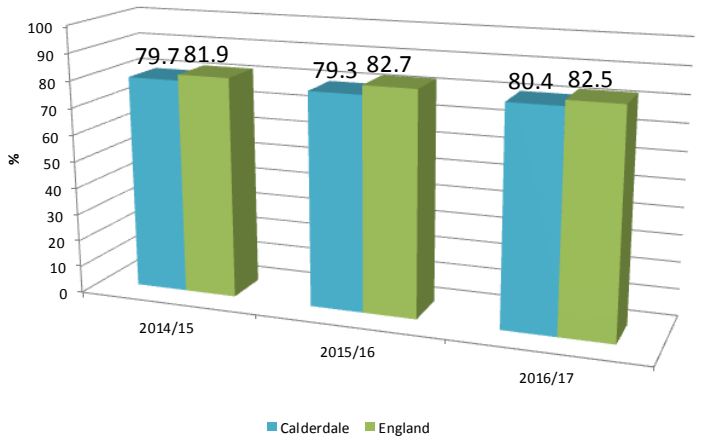


*The targets shown in the graph above are locally adopted targets from November 2014 to October 2017. From November 2017 to March 18 are the nationally agreed targets.

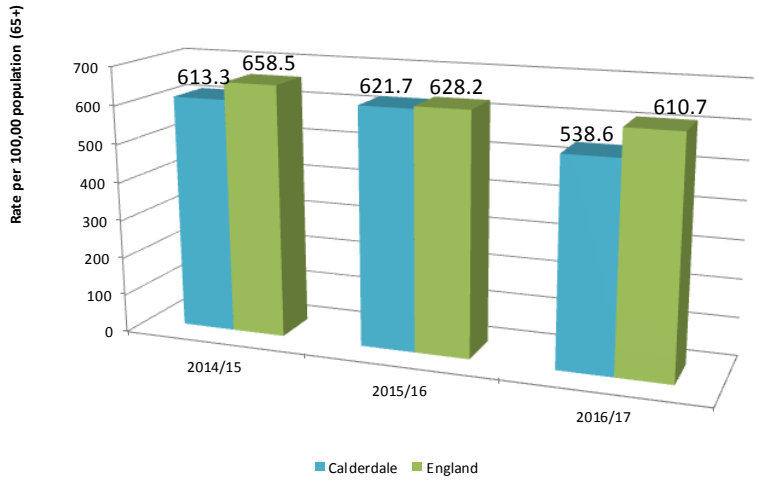
Number of non-elective admissions by quarter compared to target



The proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital in reablement/rehabilitation services



Rate of permanent admissions to residential care per 100,000 population (65+)



Corporate Governance Report

MEMBERS' REPORT

1. Member Profiles

The CCG is a membership organisation and consists of the 26 practices that are based in Calderdale (see appendix 1 to this Members' Report). The practices work together throughout the year to improve the quality of care, access to services and experience for local people. They do this in a number of ways; through meetings of the Practice Commissioning Leads, Commissioning Team meetings, the Medicines Advisory Group and the Practice Managers Action Group.

The mechanism for engaging with the practices is set out in the commissioning engagement scheme, which is approved on an annual basis. In 2017-18, work continued on developing strong clinical engagement, as well as addressing local needs. Building on the work undertaken over the previous four years, and taking into account the current challenging financial climate, the scheme involved the CCG membership working together to:-

- Promote continuous improvement of services, quality of patient care and access to services;
- Support each other in identifying and sharing of best practice;
- Enable the review of existing services and service redesign;
- incentivise and encourage practices to analyse referrals and own referral behaviour;
- Encourage practices to manage a greater proportion of demand within a primary care/community based setting, where appropriate;
- Achieve reduced variation in referrals rates between practices.

The anticipated outcomes of the scheme, which would assist the CCG to achieve its strategic priorities, were:

- An improvement in quality and safety and improved patient experience;
- A reduction in unwarranted variation between practices in both service delivery and usage of secondary care services;
- A contribution towards financial recovery across the healthcare system;
- Supporting shift from unplanned to planned care.

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

➢ Practice Commissioning Leads

As in previous years, each practice 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 CCG's Clinical Development Forum.

➢ Commissioning Teams

The member practices are funded by the CCG to meet together in one of five commissioning teams. They worked collaboratively to support the redesign of patient pathways – leading to improved efficiency, effectiveness and patient experience. This in turn enables investment in health improvement, prevention, and personalised care for people with long term conditions and high quality services closer to home. Practices were asked to scrutinise their own service provision and referral behaviour to consider how care might be better delivered for their patients.

In order to take this work forward, the teams were supported by representatives from the CCG's Finance, Medicines Management, Contracting and Data Quality/Information Teams and lead programme manager and the attendance at one of the meetings by a Governing Body clinician.

➢ Performance of the membership

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

- Attendance at meetings –The CCG held six Practice Commissioning Leads' meetings and four Commissioning Team Meetings, which were attended by the Practice Commissioning Lead and Practice Manager from each of the member practices. There has been excellent attendance at the practice leads meetings with practices attending the majority of meetings throughout the year;
- The sharing of peer review of referrals and non-elective admissions and A&E activity at the practice leads events;
- Evaluation of the effectiveness and value of each Practice Leads meeting carried out to inform future planning;
- The submission of the final commissioning team reports at the end of April, which the CCG uses to identify any service redesign or QIPP (Quality, Innovation, Productivity and Prevention) recommendations as well as assessing the effectiveness of the commissioning engagement scheme;
- Visits to practices carried out by a member of the Governing Body and the Chief Finance Officer/Deputy Chief Officer between September and January. These visits

took the form of a meeting which involved the majority of the practice's referring clinicians.

Peer Review

In 2017-18, the CCG funded out of hours (OOH) cover which enabled practices to carry out peer review of referrals - reviewing the Calderdale GP Dashboard and their own non-elective and A&E admissions activity. The aim is to increase the effective management of GP referrals and unplanned admissions, making best use of general practice expertise in individual specialties, using all available out-of-hospital pathways and thresholds to understand the causal factors and reduce variation across practices, localities and the CCG.

The Commissioning Teams used this practice information to further develop locality-based peer review. During these meetings, practices reviewed a selection of referrals from the wider locality to enable reflection and learning.

- **Highlights from the work of the practices**

Highlights from the work of the practices can be found in the Performance Report (see page 17-18).

2. The Governing Body and its Committees

The CCG's membership has delegated authority to the Governing Body to oversee the work of the organisation and make decisions on its behalf as set out in the Scheme of Reservation and Delegation incorporated in the CCG's Constitution (see Governance Statement). The members of the CCG's Governing Body as at the 17th May 2018 are set out below.

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

Composition of the Governing Body having authority or responsibility for directing or controlling the majority of the activities during the year 2017- 2018

Dr Alan Brook	Governing Body Chair and GP Member (retired 30 April 2018)
Dr Steven Cleasby	Governing Body Chair (from 1 May 2018); Assistant Clinical Chair (until 30 April 2018) and GP Member
Dr Majid Azeb	Assistant Clinical Chair (from 1 May 2018) and GP Member
David Longstaff	Deputy Chair/Lay Member (Audit)
Dr Matt Walsh	Chief Officer
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer
Dr Robert Atkinson	Secondary Care Specialist (from 1 June 2017)
Jackie Bird	Registered Nurse (until 31 March 2018)
Dr Helen Davies	GP member
Dr Farrukh Javid	GP Member
John Mallalieu	Lay Member (Finance and Performance) from 1 June 2018, previously the Lay Advisor to the Governing Body
Kate Smyth	Lay Member (Patient and Public Involvement)
Dr Caroline Taylor	GP Member
Dr Nigel Taylor	GP Member
Advisors to the Governing Body	
Penny Woodhead	Chief Quality and Nursing Officer
Stuart Smith	Director of Adults and Children's Health and Social Care Services (Calderdale Metropolitan Borough Council)
Paul Butcher	Director of Public Health (Calderdale Metropolitan Borough Council)

3. Register of Interests

Clinical Commissioning Groups are required to make arrangements to manage actual or potential conflicts of interest so that decisions by the CCG are made (and, importantly, are seen to be made) without the possibility of the influence of external or private interest[1]. The

[1] Section 14O of the 2006 Act, as inserted by section 25 of the 2012 Act; CCG Constitution (as revised May 2017)

CCG has a number of systems and processes in place to manage conflicts of interests. These are set out in the CCG's Constitution and our Policy on the Management of Conflicts of Interest.

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

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

4. Personal Data Related Incidents

During 2017-18, there were no personal data-related incidents that met the Information Governance Serious Incidents Requiring Investigation (IG SIRI) criteria at level 2 Severity or above.

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

5. Statement of Disclosure to Auditors

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

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

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

6. Modern Slavery Act

People who are exploited for modern day slavery purposes often experience multiple types of abuse. Because of the situation they find themselves in and because of their past experiences they are often unable to extricate themselves from the situation without considerable help from others. This is why the CCG takes modern slavery and human trafficking seriously and why the lead sits in the safeguarding team. Modern slavery and human trafficking are referenced in the CCG's Safeguarding Policy and all safeguarding

training delivered by the team includes identification of and appropriate responses to this issue.

- **Working with partners**

The CCG is an active member of the local and regional networks, working in partnership to combat modern day slavery, share good practice and help shape national policy and legislation. The CCG also monitors and seeks assurance from its commissioned providers that 'Modern Slavery and Human Trafficking' is included in their safeguarding policies and in all safeguarding training.

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

Dr Matt Walsh,
Accountable Officer
24 May 2018

List of Member Practices and Practice Commissioning Leads

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

Statement of Accountable Officer's Responsibilities

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

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- Keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction;
- Such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error;
- Safeguarding the CCGs assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- The relevant responsibilities of accounting officers under Managing Public Money;
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the NHS Act 2006 and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006; and
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

Under the NHS Act 2006, NHS England has directed each CCG 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 CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

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

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

- State whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,
- Assess the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- Use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

To the best of my knowledge and belief, and subject to the disclosure set out below, I have properly discharged the responsibilities set out under the NHS Act 2006, Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

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

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

Dr Matt Walsh,
Accountable Officer
24 May 2018

GOVERNANCE STATEMENT

1. Introduction and context

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

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

As at 1 April 2017; the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

2. Scope of responsibility

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

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

3. Governance arrangements and effectiveness

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

3.1 Governance Framework

The Governance Framework for the Clinical Commissioning Group is set out in our Constitution. It sets out the:

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

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

3.2 Responsibilities of the CCG membership body

The CCG consists of 26 member practices. They are responsible for agreeing the vision and values and overall strategic direction of the CCG. A number of decisions are reserved to the membership and these are set out in the CCG's Scheme of Reservation and Delegation, including approval of:

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

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

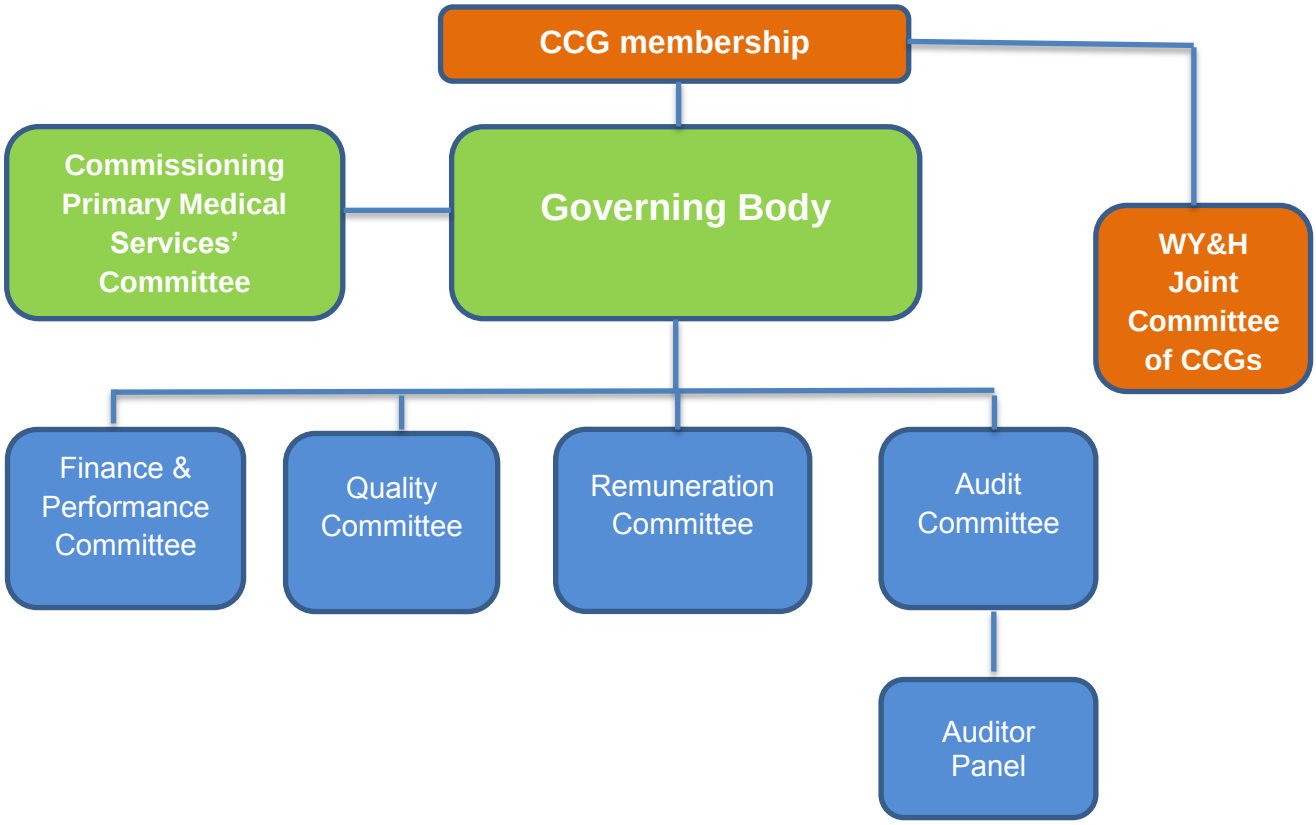
3.3 Responsibilities of the Governing Body

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

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

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

3.4 Governance Structure of the CCG



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

3.5 Work of the Governing Body

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

3.6 Governing Body key activities in 2017-18

Throughout the year, the Governing Body and its committees have maintained a robust grip on performance across the system as well as internally. It has sought and received assurance in five key areas:

Areas of assurance

The Governing Body has received the Annual Statement of Public and Patient Engagement, the Joint Safeguarding Annual Report and the annual report on Emergency Preparedness, Resilience and Recovery (EPRR).

We have also taken decisions in relation to medicines optimisation and the commissioning of lower value medicines or products.

New ways of working

As well as maintaining a robust grip on the quality and safety of care, finance and performance, the Governing Body has committed time and energy into 'turning theory into practice'. This has been with the aim of improving the wider health of the local population in a way that is financially sustainable.

In October we unanimously agreed that the CCG was supportive of the Full Business Case for hospital change as presented by Calderdale and Huddersfield NHS Foundation Trust. In doing this, the work that had taken place and the challenges that lay ahead were recognised. We committed to continue holding conversations about the changes in public. (Further information on hospital service change can be found in the Performance Report, page 15.)

Patient stories

The Governing Body continues to value the use of patient stories as part of the meeting. The aim of the story is both to set the tone for a meeting or a decision being made by starting with a patient focus and real life view of NHS care and to engage the 'softer' skills of decision-makers by starting the meeting from a position of empathy and shared experience. The evidence base suggests that bringing the patient voice to formal meetings reminds members of their duties and responsibilities to patients and is a positive way to engage the Governing Body and/or Senior Management Team with their overarching responsibilities. A patient story is not shared in order for Governing Body members to fix the problems experienced by individual patients, but to use each time a patient voice is brought to a meeting as an opportunity to reflect on the experiences of patients as part of a listening organisation.

Throughout 2017-18 we heard a number of stories at our Governing Body including the experience of young carers, mental health service users and the impact of living with vascular dementia on the individual and their family.

➢ Partnerships

Further information on our partnership working can be found in the Performance Report.

3.7 Governing Body Performance

As set out in the Performance Report, the CCG has delivered its statutory financial duties. Whilst there have been real challenges in terms of performance on some of the NHS Constitutional Standards, the level of performance in the Calderdale system remains strong when benchmarked with others nationally.

There has been excellent attendance at meetings by Governing Body members, advisors and officers, with the right level of scrutiny and discussion in the meetings.

The Governing Body has needed to make a number of difficult decisions during the year and has shown real leadership and commitment to improving services for local people throughout.

The committees have provided the right level of assurance to the Governing Body with the Finance and Performance Committee having a clear focus on financial recovery, overseeing the development of strengthened approach to the internal governance of the QIPP (Quality, Innovation, Productivity and Prevention) and Financial Recovery Plan. The Quality Committee has presented a clear view through the use of the Quality Dashboard of the quality and safety issues that are being addressed by our providers. The Commissioning Primary Medical Services Committee has made a number of important decisions about GP practice contracts demonstrating a high level of scrutiny and commitment to ensuring that patients are receiving good quality care. The Audit Committee has provided important assurance to the Governing Body about the robust governance and risk management arrangements as well as the systems of internal control in place. This assurance is supported by the independent audit reports produced by Audit Yorkshire. Finally, the Remuneration Committee has ensured that we have a robust process in place for making sound remuneration decisions whilst managing the conflicts of interest.

3.8 Governing Body and Committee effectiveness

The Governing Body and its committees carried out its annual self-assessment during January to March. The focus this year was on Governing Body and committee effectiveness, getting the balance right between formulation of strategy and assurance, setting the culture for the organisation, having the right balance of experience and skills on the Governing Body, leadership and readiness for working in different ways with partners across Calderdale.

The review demonstrated a high degree of confidence in the workings of the Committees, governance arrangements and systems of internal control.

➢ **Actions identified for 2018-19**

- Continue to create space for development discussions and consideration of strategic priorities;

- Further develop the role of individual Governing Body members in partnership discussions as part of Calderdale Cares, across the hospital footprint and the West Yorkshire & Harrogate health and care partnership;
- Strengthen the leadership of the Governing Body in setting the culture of the organisation;
- Use the self-assessment findings and understanding of the future direction for the CCG to inform an organisational development plan for the Governing Body.

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

3.9 Work of the Governing Body committees

➢ 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. It also has the responsibility for monitoring and reviewing the quality agenda as it pertains to the co-commissioning of Primary Medical Services. The Quality Committee submits a comprehensive Quality and Safety report to every meeting of the Governing Body. This provides updates on key quality activities related to patient safety, clinical effectiveness and patient experience.

The Committee is supported by the Heads of Primary Care Quality and Improvement, Service Improvement and the Public Health Consultant (Calderdale Council).

The Committee's work programme has increased significantly this year, particularly in relation to the number of service specifications being reviewed; the quality and equality impact assessments and consultation results being reviewed (some as part of the financial recovery programme); and the quality work associated with the Right Care, Right Time, Right Place programme of work.

Work of the Quality Committee: Highlights

Clinical Audit activity

The assurance process for audits and NICE guidance was reviewed. Assurance will continue to be sought from providers that relevant national audit recommendations had been considered and that action plans are in place if required. Evidence of compliance with NICE guidance will continue to be sought from providers. The quality team will continue liaise with contracting and service improvement colleagues on any changes in national guidance.

Service Specifications

A full programme of reviewing draft service specifications, Quality Impact and Equality Impact Assessments has been carried out. The review of the service specifications is informed by patient experience survey results as well as national best practice e.g. NICE guidance.

➢ 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. Detailed finance, contracting, recovery and performance reports are submitted to each of the Governing Body meetings.

The membership and attendance at the committee can be found in appendix 1 to the Governance Statement. The Committee is supported by the relevant Heads of Service and the Performance Manager.

Work of the Finance and Performance Committee: Highlights

Delayed Transfer of Care (DTOC)

The Committee has played a key role in improving the DTOC position in Calderdale. This currently ranks as one of the strongest nationally.

Clear focus on financial recovery

The favourable year-end position demonstrates the level of focus and grip exerted by the Committee during the year.

As noted in last year's annual report, the Committee has changed the way it conducted its business in line with the advice given by out external auditors. This new way of working has become established over the past 12 months with the Committee holding quarterly full meetings and then the intervening meetings focussing clearly upon financial recovery and receiving exception reports on other key areas of responsibility. The Committee feels this has worked well by focussing its attention to risk.

The Committee has overseen the development of a strengthened approach to the internal governance of the QIPP (Quality Innovation, productivity and Prevention) and Financial Recovery Plan.

➢ Commissioning Primary Medical Services Committee

The Commissioning Primary Medical Services Committee (CPMSC) has been established by the Governing Body as a corporate decision making committee. It has responsibility for the management of the functions and powers delegated to the CCG by NHS England as part of the 'co-commissioning' of primary medical services. The functions of the Committee are undertaken in the context of the aim to increase quality, efficiency, productivity and value for money. It makes decisions on the review, planning and procurement of primary medical care services in Calderdale. This includes:

- Contracts for General Medical Services (GMS), Primary Medical Services (PMS) and

Work of the CPMS Committee: Highlights

- Primary Care Assurance Report developed to provide metrics against 9 domains including: Care Quality Commission ratings, Friends and Family Test, GP patient survey and emergency admissions.
- Decisions on investment of PMS (Primary Medical Services) premium funding; progress reported throughout the year.
- Performance of two Alternative Providers of Medical Services (APMS)' Contracts scrutinised by the committee.
- Monitored primary care budget position throughout. Reports encompass delegated and non-delegated budgets to provide a complete picture.

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

The Committee is supported by the Heads of Primary Care Quality and Improvement, Finance, Contracting and Procurement and Corporate Affairs and Governance. The Leader of the Council in his role as joint Chair of the Health and Wellbeing Board attends as well as representatives from Healthwatch and NHS England.

CPMSC meetings are held in public and in 2017-18 met on five occasions. It has also held three development sessions.

➢ Remuneration Committee

The Remuneration Committee has two key functions: It makes 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/Deputy Chief Officer. It also has responsibility for reviewing and approving Human Resources Policies.

In 2017-18, the committee was supported by the Human Resources Manager and the Head of Corporate Affairs and Governance.

Work of the Remuneration Committee: Highlights

- Reviewed and made determinations on Governing Body, Very Senior Managers and Associates' remuneration, whilst ensuring robust management of conflicts of interest.
- Approved 10 HR policies. The aim, where-ever possible is to have consistent policies across Calderdale, Greater Huddersfield and North Kirklees CCGs to support shared staff.
- Sought and been provided with assurance regarding the Governing Body member appraisal process.
- Reviewed the model of Associates to assess the contribution, effectiveness and value for money of Associates and whether it had delivered the anticipated benefits. A continuation of the model was supported with amendments to the Associates Policy.

➢ Audit Committee

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

management of conflicts of interest. It is supported in carrying its role by independent audit reports produced by Audit Yorkshire (Internal Auditors) and KPMG (External Auditors).

The committee is supported by the Chief Finance Officer/Deputy Chair and the Head of Corporate Affairs and Governance. Both external and internal auditors attend the meetings.

Work of the Audit Committee: Highlights

- Sought and received assurance about the additional systems and processes being put in place to manage conflicts of interest.
- Kept under review contract management and tender waivers.
- Oversaw the information governance arrangements leading to an achievement of **100%** compliance with the Information Governance Toolkit. Keeping under review the preparations for the new General Data Protection Regulation.
- Sought and received a Head of Internal Audit Opinion of **Significant Assurance** that a generally sound system of internal control, designed to meet the organisation's objectives is in place.

Emergency Preparedness, Resilience and Response (EPRR)

The CCG continues to place a high importance on working with colleagues to ensure appropriate Emergency Preparedness, Resilience and Response. The organisation has been self-assessed as demonstrating substantial compliance against the EPRR core standards for 2017-18. This was supported by the Audit Yorkshire's opinion of High Assurance. All actions identified during the review have been completed.

3.10 Joint working

In 2017, all the member practices from the 11 CCGs across West Yorkshire and Harrogate (WY&H) Health and Care Partnership approved the establishment of a Joint Committee of CCGs.

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

The Joint Committee was established in May 2017, with delegated authority to take commissioning decisions at a West Yorkshire and Harrogate level on specific programmes: cancer, elective care/standardisation of commissioning policies, mental health, stroke and urgent care. The Joint Committee aims to ensure that its decisions have the right public and patient engagement, clinical input and authority from the CCGs.

The Joint Committee is governed by a work plan, Memorandum of Understanding and Terms of Reference, which were agreed by the CCGs. The Committee's work plan reflects the partnership priorities for which the CCGs believe collective decision making is essential.

During the year, the Committee reviewed its work plan and asked the CCGs to approve changes to it for 2018-19.

Although it can only make decisions on the programmes of work that have been delegated to it, the Committee also makes recommendations to the CCGs on other matters where it feels that a WY&H-wide approach would be beneficial.

In March 2018, Calderdale CCG's Practice Commissioning Leads voted on behalf of their practices on the amendments to the voting arrangements for the Joint Committee and on their proposed work plan for 2018-19.

The Committee is made up of 2 representatives from each of the WY&H CCGs – usually the CCG Clinical Chair and the Accountable Officer. To make sure that decision making is open and transparent; the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the Health and Care Partnership team and NHS England also attend. The Committee meets in public in alternative months, and meetings are streamed 'live' on the committee's webpages. In 2017-18, the committee met on five occasions, with the first meeting being held in July 2017. Calderdale CCG is represented on the joint committee by the Chair and Chief Officer. Calderdale CCG attendance at this committee can be found in appendix 1 to this Governance Report.

The terms of reference for the WY&H Joint Committee of CCGs can be found on the CCG's website: https://www.calderdaleccg.nhs.uk/key-documents/#ToR

Work of the Joint Committee: Highlights

Elective care/standardisation of commissioning policies

- Agreed an approach in which before surgery, patients are offered a choice of services to address lifestyle factors.
- Agreed to standardise commissioning policy across West Yorkshire & Harrogate for procedures of limited clinical value and elective orthopaedic surgery.

Cancer

- Cancer Alliance to develop a common set of agreed outcomes and stronger system leadership to support all partners to make good, evidence-based decisions.

Mental Health

- Development of new care models for CAMHS & Adult Eating Disorders.
- Will develop a joint approach to commissioning acute mental health services.

Stroke

- Recommended that each CCG agree an aspiration to detect and treat 89% of patients with Atrial Fibrillation; adopting a targeted and phased approach to working with their local practices.

Urgent and emergency care

- Recommended a formal procurement' approach which would enable the service model to be refined with providers. This was particularly important given the complexity of delivering services in 3 STP areas across Yorkshire and the Humber.

4 Compliance with the UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, as the UK Code is based on the underlying principles of good governance (accountability, transparency, probity and sustainability of the organisation over the longer term) we have undertaken a self-assessment of the CCG's systems and processes against those principles that are relevant to the CCG. We have identified three areas where we have developed in 2017-2018 and continue to do so into 2018-19:

B1, B2.2: Ensuring the appropriate balance of skills, independence, experience and knowledge on the Governing Body and its committees

In 2017-2018, we undertook further work to ensure that the above principle was incorporated into the functioning of the CCG. This was considered prior to going out to recruitment for the Registered Nurse and GP member, to ensure that the balance of the Governing Body membership reflected the strategic direction for the CCG. Our view of the balance of the Governing Body and committee membership also formed part of the annual self-assessment and development discussion for the Governing Body in March 2018. We will continue with this focus in 2018-19.

B1.1: Determining whether a lay member is independent in character and judgment and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the lay member's judgment.

We have introduced the appropriate conflict of interest checks at interview and pre-employment for all staff and Governing Body members. The DBS pre-employment checks have been expanded for Governing Body members to incorporate the 'Fit and Proper Person' checks. From April 2018, all Governing Body members will be required, on an annual basis, to confirm their 'Fit and Proper Person' status.

B4: Induction and ongoing development of the Governing Body

We continually seek to improve the way in which we provide induction to new Governing Body and committee members and enable them to remain up to date and effective in their role. We will take further action on this in 2018-19 through a Governing Body Organisational Development programme.

5 Discharge of statutory functions

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

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

Further information on how the CCG has fulfilled its statutory duties can be found in the Performance Report (Page 30). This includes compliance with the duty to consult the Health and Wellbeing Board when reviewing the extent to which the CCG has contributed to the delivery of the joint Wellbeing Strategy.

6. Risk Management Arrangements and Effectiveness

The CCG's Integrated Risk Management Framework (IRMF) describes our approach to managing risk; our risk management objectives, risk appetite and the processes in place to ensure the objectives are not only embedded within the core business of the organisation but also achieved.

The CCG's Integrated Risk Management Framework can be on the CCG website: https://www.calderdaleccg.nhs.uk/wp-content/uploads/2018/01/Integrated-Risk-Management-FrameworkFeb-2017_FINAL-Uploaded-09.01.18.pdf.

The CCG manages and reports on risk in two ways:

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

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

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

➢ Risk Identification

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

- Performance indicators reporting variance from plan within commissioning performance contracts and related reports;

- The results of planned reviews of compliance with statutory and regulatory requirements e.g. fire regulations, Care Quality Commission (CQC) standards and reviews, Ofsted reviews, information governance systems including the IG Toolkit;
- Routine review of serious incidents, incident reports and complaints to identify emerging risks, themes or specific concerns;
- Utilisation of intelligence through partners and stakeholders;
- Ensuring contact with regional and national professional associations that provide early warning of serious adverse events;
- Risk review and discussion through operational meetings (Senior Management Team, project or programme management or contract management meetings) and the formal governance arrangements, i.e. Governing Body and its Committees, which highlight risks that need to be reflected in the Risk Register, assess the mitigating/management actions and risk rating.

➢ Risk assessment and risk rating

Risk assessment is a structured process that is used once a risk has been identified. In assessing the risk score, the potential impact and likelihood of the risk materialising are taken into consideration together with the controls that are already in place to manage the risk, together with their effectiveness. A 5x5 (Likelihood x Impact) matrix is used to arrive at the risk rating.

The target score is identified by assessing the additional controls that can be put in place together with level at which the risk can be accepted - taking into account the CCG's risk appetite.

➢ Risk Recording, Reviewing and Monitoring

The CCG has an integrated approach to risk, with the recording and monitoring of risks co-ordinated through a single, on-line risk register. The on-line risk register systems allows for an auditable two tiered review process and supports the monitoring and updating of risks within review deadlines.

Once every risk cycle, the Senior Management Team (SMT) reviews all the risks on the register, identifies any new risks; assesses the actions to manage/mitigate the risk and the risk rating. The Quality, Finance and Performance and Commissioning Primary Medical Services (CPMS) Committees review risks relating to their remit. Risks rated as 'Serious' i.e. at 15 or above are submitted to each of the Governing Body meetings. Commissioning Primary Medical Services risks rated 15 or above are also reported into the CPMS Committee. A 'Critical Risk' report, with an associated action plan is produced for risks rated 20 or above.

➢ Risk Appetite

The CCG's aim is to minimise the risk of harm wherever possible to service users, the public, staff, members and other stakeholders. However, the CCG also recognises the need to take

considered risks in some areas (for example, transformation / re-design of services) and that an overly risk averse approach can be a threat to the achievement of some strategic objectives.

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

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

The CCG's risk management system is complemented by other control systems and programme management approaches which are designed to deliver assurance on the prevention and/or management of existing risks. Other control systems include our approach to equality impact assessments and quality impact assessments which form an integral part of service improvement and recovery proposals, approval of service specifications and commissioning policies.

Risk management of potential fraud, bribery and corruption, information governance and conflicts of interest are all supported with the appropriate policies and mandatory training for all staff and Governing Body members as well as briefings and audits of compliance. All these mechanisms, together with the use of the intelligence provided by performance, quality and safety dashboards as well as partner and stakeholder engagement puts us in a stronger position to prevent/manage risks to the CCG.

- **Incident reporting**

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

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

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

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

- **Involving partners and other stakeholders**

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

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

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

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

This is achieved by the following:

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

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

- **Capacity to Handle Risk**

The CCG has a robust and systematic approach to risk management. The Chief Officer is supported by the Senior Management Team in ensuring that the CCG has a positive and open approach to the identification and management of risk.

- **Effectiveness of Governance Structures**

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

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

relevant risks rating 15 or above at each of its meetings in public and an update on all relevant risks on a six monthly basis.

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

- Ensuring that the Integrated Risk Management Framework is up to date;
- Reports and copies of the GBAF for review twice a year prior to its submission to the Governing Body;
- Six monthly reports on the effectiveness of the risk management system;
- Annual reports from the committees which set out their review of the delivery of their terms of reference, annual work plan and self-assessment of their effectiveness and the effectiveness of the risk management arrangements.
- Independent reports from Audit Yorkshire on the findings of the annual mandated audit of governance and risk management.

➢ Responsibilities of the Senior Management Team and Committees

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

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

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

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

The Audit Committee 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 statutory obligations**

The assessment of risks is a continuous process informed by:

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

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

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

This level of oversight, which has been supported by the detailed work of the Committees, has placed the CCG in a stronger position to deliver its performance, quality and financial targets.

- **Staff and Governing Body training**

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

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

- **Risk Assessment**

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

- Through **internal governance arrangements** taking account of self-assessment activity, the review of the CCG Constitution and standing financial instructions, new national guidance or regulations and the findings from external inquiries
- Through the **annual internal audit**, **anti-crime and local security management** plans carried out by Audit Yorkshire. These include the annual mandated reviews of the CCG's risk management and governance arrangements as well as audits in specified areas as identified following a risk assessment of all areas of the CCG's activities.

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

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

➢ **Major Risks to Governance, Risk Management and Internal Control**

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

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

The Finance and Performance Committee maintains a robust grip on these risks through regular finance and contract reporting and the review of the risk register.

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

7. Other sources of assurance

Internal Control Framework

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

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

- **Governing Body Assurance Framework (GBAF)**

The GBAF is a simple but comprehensive method for the effective and focused management of the principal risks to meeting the strategic objectives of the CCG. The GBAF deals with strategic and long term risks / threats whereas the Risk Register is used to identify and manage performance based (operational) risks that may rise and fall within relatively short term periods. A summary of the principal risks to the CCG's licence and delivery of its strategic objectives is set out in appendix 3 to this governance statement.

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

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

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

The Governing Body Assurance Framework is formally reviewed twice per annum and is reviewed by the Audit Committee prior to submission to the Governing Body for approval. The GBAF continues to be updated to ensure that it sufficiently reflects the increasing focus of our work with partners on the Health and Wellbeing Board to deliver the Single Plan for Calderdale, work with the West Yorkshire and Harrogate Health and Care Partnership and system financial recovery.

The GBAF is considered by all the Governing Body Committees enabling a detailed review of the strategic objectives, risks to achieving these and the effectiveness of the controls in place.

8. Annual audit of conflicts of interest management

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

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

- Continue to ensure that the information contained within the Declaration of Interest portal matches up with the information published on the Register.
- Continue to work towards the training compliance level of 90% before the submission to NHS England on 31st May 2018.

9. Data Quality

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

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

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

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

Improving access to information about agreed clinical pathways

In 2017-18 the CCG continued develop a single 'in-consultation' tool. This provides easy access for GPs to the most up to date locally agreed clinical referral pathways, guidelines and referral forms (for example: Musculo-skeletal pathway and mental health) .

Referral paperwork is continually under review. The content and quality of information that the MSK service is receiving is helping them more effectively triage and direct patients to the most appropriate clinician.

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

10. Information Governance

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

I am pleased to be able to report that the CCG has self- assessed as achieving level 3 against 23 standards, (with 5 areas classed as not relevant to the responsibilities of the CCG) in the IG Toolkit, with an overall grade of 'satisfactory'.

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 and comply with those policies, systems and processes.

We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit. We have a robust annual IG action plan and have ensured all staff and Governing Body members undertake the annual information governance training and the information governance handbook is available to all staff so that they are aware of their information governance roles and responsibilities. I am pleased to be able to report 100% compliance with the mandatory training.

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

11. Business Critical Models

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

12. Third Party Assurances

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

13. Control Issues

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

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

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

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

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

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

Calderdale CCG has a rating of **GREEN** for the Quality of Leadership indicator on latest available results on MyNHS (as at 18 March 2018). This rating is supported by the results of our 360 stakeholder survey in which 90% of respondents felt that they had effective working relationships with the CCG, 87% respondents felt that the CCG was an effective local system leader and 90% respondents felt that there was clear and visible leadership.

The year end results for the Quality of Leadership Indicator (CCG Improvement and Assessment Framework) will be available from July 2018 at https://www.nhs.uk/service-search/performance-indicators/organisations/ccg-well-led?ResultsViewId=1175.

15. Delegation of Functions

The West Yorkshire and Harrogate Joint Committee of CCGs has been established as a committee with certain delegated authority and responsibilities as set out in the Memorandum of Understanding and Terms of Reference. The Chair and Chief Officer represent Calderdale CCG on that committee.

The minutes and reports of key decisions taken by the committee are received by the Governing Body and CCG membership in accordance with the provisions of the CCG's Constitution.

16. Counter Fraud/Anti-Crime Arrangements

The CCG's counter fraud arrangements are compliant with NHS Counter Fraud Authorities' Standards for commissioners: fraud, bribery and corruption. These arrangements are underpinned by the engagement of a qualified Local Counter Fraud Specialist (LCFS) from Audit Yorkshire under a formal Service Level Agreement. (the current LCFS was nominated, trained and approved by NHS Protect and accredited by the Counter Fraud Professional Board in 2016); the implementation of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer/Deputy Chief Officer as the executive lead for counter fraud.

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

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

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

17. Head of Internal Audit Opinion

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

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

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

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

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

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

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

- The **Audit Committee** has oversight of the CCG's financial systems, financial information, risk management and systems of internal control, audit, information governance and business continuity. It is supported in its role by independent audit reports produced by Audit Yorkshire and regular meetings with the internal and external auditors. We have received an overall Head of Audit Opinion of **significant assurance** in 2017-2018.

- At a Committee level the **Finance & Performance, Quality and Commissioning Primary Medical Services Committees** are responsible for keeping under review the governance arrangements relating to their remit. This includes review of all relevant risks and review of the principal risks to the achievement of our strategic objectives in 2017-18. The Commissioning Primary Medical Services Committee receives all

relevant risks rated 15 or above at each of its meetings in public and all CPMSC risks twice a year.

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

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

  The Local Counter Fraud Specialist (Audit Yorkshire) completes a counterfraud self-assessment on behalf of the CCG for submission to NHS Counter Fraud Authority on an annual basis.

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

Conclusion

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

Dr Matt Walsh,
Accountable Officer
24 May 2018

CCG Governing Body and Committee Membership and Attendance

(As at 17 May 2018)

Governing Body		
Member	**Role**	**Attendance**
Dr Alan Brook	Chair and GP member [2] (until 30 April 2018)	8/8
Dr Steven Cleasby	Chair (from 1 May 2018) and GP Member	1/1
Dr Steven Cleasby	Assistant Clinical Chair (until 30 April 2018) and GP Member	7/7
Dr Matt Walsh	Chief Officer (Accountable Officer)	6/8
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	6/8
David Longstaff	Lay Member (Audit) and Deputy Chair	7/8
Dr Majid Azeb	GP Member (Assistant Clinical Chair from 1 May 2018)	7/8
Dr Nigel Taylor	GP Member	7/8
Dr Caroline Taylor	GP Member	7/8
Dr Helen Davies	GP Member (from 1 April 2017)	5/8
Dr Farrukh Javid	GP Member (from 1 April 2017)	7/8
Kate Smyth	Lay Member (Patient and Public Involvement)	8/8
John Mallalieu	Lay Member (Finance and Performance) - From 1 June 2017[3]	7/7
Jackie Bird	Registered Nurse (until 31 March 2018)	7/7
Dr Rob Atkinson	Secondary Care Specialist – From 1 June 2017	5/7
Advisors to the Governing Body		
John Mallalieu	Lay Advisor (Finance and Performance) - Until 31 May 2017	1/1
Penny Woodhead	Chief Quality & Nursing Officer	8/8
Paul Butcher	Director of Public Health (Calderdale Council)	5/8
Stuart Smith	Director of Adult and Children's Health and Social Care Services (Calderdale Council)	5/8

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

[3] Previously Lay Advisor to the Governing Body

Finance and Performance Committee (as at 17 May 2018)		
Member	**Role**	**Attendance**
Dr Nigel Taylor	Committee Chair and GP Member	10/13
Dr Matt Walsh	Chief Officer (Accountable Officer)	9/13
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	11/13
Dr Steven Cleasby	GP Member	12/13
John Mallalieu	Lay Advisor (Finance and Performance) - Until 31 May 2017 Lay Member (Finance and Performance) - From 1 June 2017	1/2 11/11
Dr Farrukh Javid (in attendance)	GP Member	9/13
Kate Smyth	Lay Member (PPI) - Deputy for the Lay Member (Finance and Performance)	0/1
Quality Committee (as at 17 May 2018)		
Member	**Role**	**Attendance**
Dr Majid Azeb	Committee Chair and GP Member	10/13
Dr Caroline Taylor	GP Member and Vice Chair of the Committee	13/13
Kate Smyth	Lay Member (Patient and Public Involvement)	13/13
Penny Woodhead	Chief Quality & Nursing Officer	12/13
Dr Helen Davies (in attendance)	GP Member	13/13
Emma Bownas	Quality Manager (Designated deputy for Head of Quality)	1/1
Commissioning Primary Medical Services Committee (as at 17 May 2018)		
John Mallalieu	Committee Chair and Lay Member (Finance and Performance) - from 1 June 2017	6/6
Dr Matt Walsh	Chief Officer (Accountable Officer)	6/6
Kate Smyth	Lay Member (Patient and Public Involvement) (Vice Chair of the Committee)	6/6
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	5/6
Jackie Bird	Registered Nurse (until 31 March 2018)	4/6
Dr Alan Brook	GP Member	6/6
Dr Steven Cleasby	GP Member	6/6
Dr Rob Atkinson	Secondary Care Specialist – From 1 June 2017	3/6

Audit Committee (as at 17 May 2018)		
Member	**Role**	**Attendance**
David Longstaff	Lay Member (Audit) and Chair	7/7
John Mallalieu	Lay Member (Finance and Performance) - from 1 June 2017 Lay Advisor (Finance and Performance) - Until 31 May 2017	6/6 1/1
Kate Smyth	Lay Member (Patient and Public Involvement)	7/7
Jackie Bird	Registered Nurse	4/5
Dr Caroline Taylor	GP Member	6/7
Dr Nigel Taylor	GP Member	1/1

West Yorkshire and Harrogate Joint Committee of CCGs (as at 15 April 2018)		
Calderdale CCG Member	**Role**	**Attendance**
Alan Brook	Governing Body Chair	5/5
Matt Walsh	Chief Officer	4/5
Neil Smurthwaite	Chief Finance Officer/Deputy Chief Officer	1/1

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

Summary of major risks to the CCG's governance, risk management and internal control (2017-18)

Risk No.	Risk Summary	Action to mitigate	Means to assess outcomes
62 RR: 20	Risk that the system will not deliver the NHS Constitution 4-hour Accident & Emergency target due to demand, capacity and patient flow.	- Use of non-recurrent West Yorkshire A&E Acceleration Zone funding to improve capacity and access; - A&E/primary care streaming services and social work assessment and home-care capacity; - Trialing a new primary care service at A&E; - Surge and Escalation and Winter Plans refreshed and learning identified from the pressures experienced during the early part of December.	- The monthly A&E Delivery Board reviews capacity and demand issues from the system and potential solutions. - Continued risks and actions to mitigate identified through the A&E Delivery Board. - Production of Critical Risk Reports for review at SMT and Governing Body meetings.
In-year major risks that have a reduced risk rating at the end of March 2018			
709 Reduced from RR: 20 to 16	Risk of delays in patient transfer of care (TOC) due to (a) a lack of NHS capacity non-NHS services outside hospital, and (b) health and social care systems and processes not currently being optimised.	- A formal TOC Improvement Plan; visibility and commitment being built within each A&E Delivery Board partner; - Providers share data on delays and mitigating actions; - System engaged in national Ambulatory Care and Frailty programmes (national models of good practice) - Dedicated time to develop new ways of working to improve patient flow and patient experience.	- TOC real-time dashboard provides a system overview of patients who on a discharge pathway. - Commissioners see an aggregated version enabling progress to be assessed. - Finance and Performance Committee review performance against the TOC Improvement Plan.
829 Reduced from RR: 20 to 16	The CCG will fail to deliver its financial plan. The 17/18 financial plan includes a number of pressures/risks which will need to be mitigated to ensure delivery. These risks include activity pressures on acute contracts (contract value higher that CCG affordability) unidentified savings, prescribing, continuing health care and under-	- Financial Recovery Plan finalised during ; - Focus on: Eliminating waste; Ensuring services are performing as expected; Transactional work; new models of funding and financial flows; Stopping things; - Recovery Group ensuring recovery and leadership. - CHFT Transformation Group to coordinate and triangulate CCG QIPP schemes and CHFT Cost	- SMT reframed on a monthly basis as the Recovery Group monitoring progress and identifying solutions. - Update reports into Finance and Performance Committee and Governing Body

	delivery of QIPP.	Improvement Programme; - Development of a system response with shared ownership of recovery (2 CCGs and CHFT) and agreement of Head of Terms.	
1024 RR: 16	Risk is that Calderdale CCG may not have the sufficient or appropriate QIPP schemes in place to ensure that its contribution to the health system model is affordable going forward. This may result in the non-achievement of control total through non achievement of QIPP/saving targets.	- Monthly QIPP tracker reporting to Recovery Operational Group, SMT Recovery, F&P committee and Governing Body; - Clinical engagement in QIPP programmes; - Medium term financial planning process in place; - Financial and contracting reporting arrangements in place through Senior Management Team, Finance and Performance Committee, and Governing Body; - Health system financial recovery plan being developed jointly with CHFT & Greater Huddersfield CCG, looking at total level of savings required and models for sustainability; - STP Financial strategy being developed for consistent approach across West Yorkshire & Humberside.	- Internal audit reports. - Finance, contracting and QIPP reports. - Area Team assurance role.
1023 RR: 16	The CCG will fail to deliver our 17/18 planned in year deficit of £3.13m and therefore fail to deliver a planned £2.7m cumulative surplus. The 17/18 financial plan included a number of pressures/risks which have been mitigated to ensure delivery. These risks include activity pressures on acute contracts, prescribing and under-delivery of QIPP. This resulted in the CCG not achieving its financial targets and forecasting a reduced surplus position for the year end.	- The financial plan has been approved by Governing Body; - A QIPP plan has been agreed at £11.5m but there is a £4.3m risk to achieving this; - There is a monthly budget monitoring process in place which reviews all expenditure against budgets and is shared with budget holders; - The financial plan includes a £1.6m contingency budget to manage in year risk.	- Internal and external audit reports. - Role of Audit Committee. - Quarterly Area Team Assurance Process where the CCG financial position is assessed. - Monthly reporting to Finance and Performance Committee and Governing Body.

1069 RR: 16	As a result of the implementation of the Electronic Patient Record (EPR) at CHFT there is a risk that patient safety will be compromised due to: 1) a lack of or delayed information received in GP practice following attendance at the hospital 2) difficulties in booking fast track appointments in a timely manner, (this has now been resolved with very few issues remaining) 3) difficulties in reconciling medications following attendance at the hospital All of the above having a negative impact on access to primary care. Delayed information may result in a delay in treatment and or access to services for patients.	- Impact of the implementation of EPR is a standing item on the agenda for Clinical Quality Board, Contract Management Board and A&E Delivery Board; - GP requested to log all incidents relating to EPR Incidents monitored by the Quality Team/risk teams at the CCG and reported back to CHFT to take action as appropriate; - Planned CCG "go see" visits to observe EPR working and report back to Quality Committee; - Re-established the multi-agency working Group to work through on-going issues; - Developed a recovery plan which will be shared at Clinical Quality Board; - Team of staff established to work through the delayed correspondence and send on accordingly; - CHFT liaising directly with GPs and are visiting practices to verify that correspondence is being received; - IT team visiting practices to ensure EPR GP portal is accessible, all Calderdale S1 practices are live.	- Standing item on agenda for formal meetings with CHFT. - Continue to report into Quality Committee on a monthly basis until further assurance is reached. - Regular discussions between quality team and EPR team.
1116 RR: 16	There is a risk of not sustaining delivery of the new target for reportable delayed transfers of care (DTOC) set by NHSE, due to technical difficulties associated with the data period used by NHSE to construct the trajectory, resulting in the Calderdale system potentially losing control on the way BCF and IBCF funding in allocated locally.	- Joint (CCG, CMBC) executive representation at a meeting with NHSE in London; - DTOC Delivery Plan Developed and shared with NHSE; - Case made to NHSE for a revised trajectory.	- Joint (CCG, CMBC) executive representation at a meeting with NHSE in London. - DTOC Delivery Plan Developed and shared with NHSE. - Case made to NHSE for a revised trajectory.
1113 **RR:**16	There is a risk that the 2 national Continuing Healthcare (CHC) assurance targets will not be achieved: <15% of assessments to be carried out in an acute environment >80% of assessments must be	- Work with key stakeholders to agree new ways of working and gain cooperation; - Improvement plan and monthly trajectory submitted to NHSE; - Clinical lead and Operations manager in CHC team working closely with their team and colleagues in	- New senior management in place at Calderdale Council working in a positive manner to implement discharge to assess.

	completed within 28 days - This is due to delays in allocation of social workers This means that the CCG will not achieve the quality premium and will be identified as underperforming and subject to scrutiny from NHSE	Calderdale Council and CHFT to deliver new ways of working/monitor all parts of the process and escalate and manage delays; - Weekly oversight and performance management by Head of CHC.	
984 RR: 16	Avoidable Health Care Associated Infections (HCAI) not being prevented due to omissions in the provision of care resulting in avoidable patient harm. The risk is further increased due to the capacity within the Infection Prevention and Control function provided by the Calderdale Council	- There is an HCAI Improvement Plan in place monitored by the HCAI Health Economy Group quarterly, and reviewed by Quality Committee quarterly; - Post Infection Reviews (PIRs) are undertaken on all CDI and E-Coli cases, outbreaks and associated deaths; - PIR reports are discussed at the HCAI group and Quality Committee to share lessons learnt; - The IPC lead from the Calderdale Council or quality manager are involved in the PIR process; - Antibiotic prescribing is monitored and prescribing benchmarked against national figures; - Reducing antimicrobial prescribing remains within the national CQUIN scheme for acute providers in 2017-2019.	- CHFT HCAI board reports are received at the HCAI Health Economy meeting, including assurance on training data, audit, hand hygiene compliance and high impact intervention compliance data. - HCAI group monitors progress of the action plans/programmes and reports the number of avoidable against unavoidable cases, this meeting is held monthly to support the timely identification of cases. - Performance data and CCCG HCAI Improvement Plan update reported via Quality Committee quarterly.

Governing Body Assurance Framework: principal risks to the achievement of the strategic objectives and compliance with the CCG's licence and actions identified to mitigate these risks in 2017-18

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

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

		We are unable to deliver our strategic intent for primary care due to capacity challenges within general practice to enable them to engage in the wider strategic change agenda, resulting in a failure to fully implement new models of care in Calderdale.	▪ Engagement of practices through the Commissioning Engagement Scheme ▪ Practice Managers' Action Group inputs to clinical commissioning and shares information with member practices on behalf of the CCG
3.	**Improving value**	We do not deliver a financially sustainability plan within our health and social care system as a result of costs and demand for services being more than our financial allocation. Failure to deliver significant QIPP/CIP savings across the sector will mean statutory financial duties being failed and RCRTRP plans unachievable.	▪ Development and delivery of short/medium term financial recovery plan ▪ 5 year Strategic Plan details actions to reduce demand and reliance on unplanned hospital based care by shifting planned community services, reducing financial risk ▪ Development of Closer to Home model to reduce increasing demand on acute services (CC2H)
4	**Improving governance**	We don't comply with statutory and other duties, leading to a failure to make legally binding decisions, opening the CCG to challenge, waste of valuable resources and potential reputational damage.	▪ Compliance with the provisions of the CCG's Constitution which has been reviewed by NHS England ▪ Annual review of committee terms of reference includes review of any changes to the statutory and regulatory framework
		We don't have effective governance and risk management processes in place due to not having the right structures, capacity and capability	▪ Robust governance structure, integrated risk management framework and systems of internal control in place ▪ Process for regular review of governance and risk management part of internal audit annual work plan

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS CALDERDALE CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 2018

Roles and Responsibilities

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

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

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

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

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

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that:

- ***Significant assurance*** **can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. 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 2017/2018 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to be embedded.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. The design of the Assurance Framework has been kept under regular review since the creation of the CCG. The Governing Body retains oversight of the design and content the Assurance Framework. The Governing Body reviews the Assurance Framework on a regular basis. The Assurance Framework is subject to regular review by both the CCG's Audit and Quality committees as confirmed through our recent audit of Risk Management Strategy and Governance Arrangements. 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 2017/18 Internal Audit Plan was approved by the Audit Committee on 18 May 2017. 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 and Risk Management
- Information / Performance Management
- Integration and Business Development
- Commissioning and Contract Management
- Financial Assurance
- Quality

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

Opinion Level	Opinion Definition	Guidance on Consistency
HIGH (STRONG)	High assurance can be given that there is a strong system of internal control which is designed and operating effectively to ensure that the system's objectives are met.	The system is well designed. The controls in the system are clear and the audit has been able to confirm that the system (if followed) would work effectively in practice. There are no significant flaws in the design of the system. Controls are operating effectively and consistently across the whole system. There are likely to be core controls fundamental to the effective operation of the system. A High opinion can only be given when the controls are working well across all core areas of the system. For example with 'Debtors' the controls over identifying income, raising debt, recording debt, managing debt, receiving debt, etc. are all working effectively – there are no serious concerns. Note this does not mean 100% compliance. There could be some minor issues relating to either systems design or operation which need to be addressed (and hence the report may include some recommendations) – however these issues do not have an impact on the overall effectiveness of the control system and the delivery of the system's objectives.
SIGNIFICANT (GOOD)	Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to ensure that the system's objectives are met and that this is operating in the majority of core areas.	The system is generally well designed - but there may be weaknesses in the design of the system that need to be addressed. In addition most core system controls are operating effectively – but some may not be. Whilst any weaknesses may be significant they are not thought likely to have a serious impact on the likelihood that the system's overall objectives will be delivered.
LIMITED (IMPROVEMENT REQUIRED)	Limited assurance can be given as whilst some elements of the system of internal control are operating, improvements are required in the system's design and/or operation in core areas to effectively meet the system's objectives.	The system is operating in part but there are notable control weaknesses. There are weaknesses in either design or operation of the system that may mean that core system objectives are not achieved. In terms of what differentiates a borderline Significant Opinion to a borderline Limited opinion – the main factors are the scale and potential impact of weaknesses found. Multiple weaknesses across a range of core areas would suggest a Limited Opinion level is applicable. However it also true that ONE weakness can suggest a Limited Opinion if it is fundamental enough to mean that a number of core system objectives will not be achieved.

Opinion Level	Opinion Definition	Guidance on Consistency
LOW (WEAK)	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the system's objectives.	The audit has found that there are serious weaknesses in either design or operation that may mean that the overall system objectives will not be achieved and there are fundamental control weaknesses that need to be addressed. It should be borne in mind that Low Assurance is not 'No Assurance.' The key point here is that there is a good chance that the system may not be capable of delivering what it has been set up to deliver – either through poor systems design or multiple control weaknesses. The report will clearly state if 'No Assurance' is actually more applicable than low assurance.

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

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level during the development phase. One advisory audit has been completed during 2017/18; this was a review of the evidence submitted by the CCG in its Information Governance Toolkit (V14.1). This work consisted of a GAP analysis which has been shared with the CCG. The Information Governance Toolkit has been revisited by Internal Audit and an assurance opinion has been provided, as below.

The outcome of the assurance audit reports from the 2017/2018 audit plan are summarised below. The audits in italics will be completed for the final Head of Audit Opinion.

Audit Area	Assurance Level
Contract / Provider Management	High
Patient and Stakeholder Engagement	High
Emergency Preparedness, Resilience and Response	High
Safeguarding Follow Up	Significant
Budget Setting	Significant
Risk Management Strategy and Governance Arrangements	High
Complaints, Incidents and SUIs	Significant
Information Governance Toolkit	Significant
Primary Care Co-commissioning	Significant
Financial Transactions	Significant
Conflicts of Interest	Significant
GDPR Readiness	Significant

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

Helen Kemp-Taylor
Head of Internal Audit and Managing Director
Audit Yorkshire
14 May 2018

Remuneration and Staff Report

Remuneration 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 (Patient and Public Involvement) and Chair of the Committee	2/2
Jackie Bird	Registered Nurse	2/2
Dr Alan Brook	GP Member and Governing Body Chair	2/2
Dr Nigel Taylor	GP Member	2/2
John Mallalieu (1)	Lay Member (Finance and Performance); Deputy Chair of the Committee from June 2017	2/2

Note1: John Mallalieu was a Lay Advisor to the Governing Body until 31st May 2017 and Lay Member on the Governing Body from 1st June 2017.

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

The Governance Statement contains further details about the role and work of the Remuneration Committee in 2017-18.

2. Policy on Remuneration of Senior Managers

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

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

- Chief Quality and Nursing Officer in her capacity as Advisor to the Governing Body.

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

The Chief Quality and Nursing Officer is also an Advisor to the Governing Body of Calderdale CCG and as such is classed as a senior manager.

To support the principle of local determination there are no set rates of pay for the different types of Senior Managers detailed above. There is, however, a range of available documentation providing guiding principles to be followed and guidance both in terms of contractual status and remuneration or reimbursement. These, together with a review of comparative data across CCGs, any recommended rates of remuneration for Very Senior Managers and legal advice, are used to inform the determinations of the Remuneration Committee.

Hutton Review Fair Pay Principles (2011):

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

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

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

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

➢ **GP Members of the Governing Body**

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

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

➢ **Registered Nurse and Secondary Care Specialist**

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

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

➢ **Lay Members**

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

3. Remuneration of Very Senior Managers (VSMs)

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

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

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

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

Note 1: The information in Table 1 above is subject to audit by our external auditors, KPMG LLP
Note 2: John Mallalieu was a Lay Advisor to the Governing Body until 31st May 2017, when he became a Lay Member of the Governing Body

Consideration of the reasonableness of the remuneration

In taking account of the factors set out in sections 2 and 3 above, the Remuneration Committee confirms that the remuneration received by the Governing Body members is considered reasonable.

Table 2: Senior manager remuneration (including salary and pension entitlements) 2016-17

Name & Title	2016/17 Staff in Post	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	Performance Pay & Bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total
		£000		£000	£000	£000	
Dr. Alan Brook, Chair	All Year	60-65	0	0	0	0	60-65
Dr. Steven Cleasby, Assistant Chair	All Year	60-65	0	0	0	0	60-65
Dr Lubna Saghir	1/8/16-31/3/17	20-25	0	0	0	0	20-25
Dr. John Taylor	Left 31/01/17	25-30	0	0	0	0	25-30
Dr. Majid Azeb	All Year	30-35	0	0	0	0	30-35
Dr. Nigel Taylor	All Year	30-35	0	0	0	0	30-35
Dr. Caroline Taylor	All Year	30-35	0	0	0	0	30-35
Dr Rajesh Phatak, Secondary Care Clinician	Left 28/2/17	10-15	0	0	0	0	10-15
Jackie Bird, Registered Nurse	All Year	15-20	0	0	0	0	15-20
Kate Smyth, Lay Member	All Year	5-10	0	0	0	0	5-10
John Mallalieu, Lay Advisor	All Year	5-10	0	0	0	0	5-10
David Longstaff, Lay Member	All Year	5-10	0	0	0	0	5-10
Matt Walsh - Accountable Officer	All Year	130-135	0	0	0	37.5 - 40.0	170-175
Julie Lawreniuk - Chief Finance Officer	Left 30/4/16	0-5	0	0	0	2.5 - 5.0	5-10
Lesley Stokey - Interim Chief Finance Officer	1/5/16 - 31/8/16	15-20	0	0	0	35.0 - 37.5	55-60
Neil Smurthwaite - Chief Finance Officer/Deputy Chief Officer	From 1/9/16 -	60-65	0	0	0	40.0 - 42.5	100-105

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

Note 2: The following Governing Body Members received payments for associate work in addition to their roles as Governing Body members: Dr M Azeb(£ 4,837), Dr N Taylor(£1,449), Dr J Taylor(£4,563)

Table 3: Pension benefits as at 31 March 2018

Name & Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in lump sum at age 60 (Bands of £2,500)	Total accrued pension at age 60 as at 31/03/18 (Bands of £5,000)	Lump sum at age 60 related to accrued pension as at 31/03/18(Bands of £5,000)	CETV at 1 April 2017	CETV at 31 March 2018	Real Increase in CETV	Employer's Contribution to partnership pension
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Matt Walsh, Accountable Officer	0 - 2.5	5.0 - 7.5	25 - 30	80 - 85	502	561	59	29
Neil Smurthwaite, Chief Finance Officer/Deputy Chief Officer	0 - 2.5	0	15 - 20	0	131	161	30	15

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

Note 2: For GP members the NHS Pensions Agency is not able to disaggregate the pensions benefits attributed to their CCG employment so are therefore not included in this table.

Note 3: The information in Table 3 above is subject to audit by our external auditors, KPMG LLP

➢ Cash Equivalent Transfer Values

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

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the

increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

4. Compensation for early retirement or loss of office

No payment has been made in compensation for loss of office or early retirement during 2017-18.

5. Payments to past senior managers

No payment has been made to past senior managers.

6. 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 rationale for the remuneration of Governing Body members including the clinical Chair is set out in section 2 above.

The banded remuneration of the highest paid Director/Member in NHS Calderdale CCG in the financial year 2017-18 was £155-£160k (2016/17: £150-155k). This was 4.65 times (2016/17: 4.33) the median remuneration of the workforce, which was £33,895 (2016/17: £35,225). In 2017-18, no employees received remuneration in excess of the highest-paid Director/Member. Remuneration ranged from £13k to £155k (2016/17: £13k to £154k).

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

Staff Report

1. CCG Workforce profile

The CCG's workforce profile is shown below and the information is based on the directly employed staff of the CCG as at 31st March 2018. Information relating to the Governing Body is reported separately.

- **Number of senior managers**

Information relating to individuals classed as senior managers for the purposes of this annual report can be found on pages 87.

2. Staff numbers and costs

Average Number of People Employed

	31-Mar-18			31-Mar-17		
	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	Number	Number	Number	Number	Number	Number
Total CCG	70	15	85	65	14	79

The staff costs and employee benefits as at 31st March 2018 are set out as in the table below:

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

2017-2018									
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Salaries and wages	4,198	3,234	964	2,581	2,020	561	1,617	1,214	404
Social security costs	393	342	51	254	215	39	140	127	12
Employer contributions to the NHS Pension Scheme	483	420	63	302	255	47	181	164	16
Gross Employee Benefits Expenditure	**5,074**	**3,996**	**1,079**	**3,137**	**2,491**	**646**	**1,938**	**1,505**	**432**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(771)	(771)	0	(395)	(395)	0	(375)	(375)	0
Net employee benefits expenditure including capitalised costs	**4,304**	**3,225**	**1,079**	**2,741**	**2,095**	**646**	**1,562**	**1,130**	**432**
Net employee benefits expenditure excluding capitalised costs	**4,304**	**3,225**	**1,079**	**2,741**	**2,095**	**646**	**1,562**	**1,130**	**432**

Table 4 (b): 2016-17 Staff costs and employee benefits

2016-2017									
	Total			Admin			Programme		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
Salaries and wages	3,912	3,052	860	2,363	1,881	482	1,548	1,171	378
Social security costs	354	321	34	227	200	28	127	121	6
Employer contributions to the NHS Pension Scheme	430	390	40	274	242	32	156	148	8
Gross Employee Benefits Expenditure	**4,696**	**3,763**	**934**	**2,865**	**2,323**	**542**	**1,831**	**1,439**	**392**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(611)	(611)	0	(288)	(288)	0	(323)	(323)	0
Net employee benefits expenditure including capitalised costs	**4,085**	**3,151**	**934**	**2,577**	**2,035**	**542**	**1,508**	**1,116**	**392**
Net employee benefits expenditure excluding capitalised costs	**4,085**	**3,151**	**934**	**2,577**	**2,035**	**542**	**1,508**	**1,116**	**392**

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

3. Staff Composition

As at 31st March 2018, the CCG directly employed 93 staff (excluding the Governing Body, but including the 2 Very Senior Managers (VSM). This equates to 86.66 whole time equivalents (WTE).

- **Gender profile**

The following table sets out the gender profile of the organisation as at 31 March 2018.

Table 5: Gender profile of the organisation

Staff and Governing Body numbers by gender				
	Governing Body (excl. Very Senior Managers)	**Very Senior Managers (VSM)**	**Staff Excl. Governing Body and VSMs**	**Total**
Female	4	0	74	78
Male	8	2	17	27
Total	**12**	**2**	**91**	**105**

Note1: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay gap report.

4. Sickness Absence

The yearly average sickness figures for the CCG between 1st April 2017 and 31st March 2018 are:

Table 6: Sickness absence data (1st January 2017 – 31st December 2017)

Total Days lost:	1038
Total Staff Years	90
Average Working Days Lost:	12

The CCG has policies and procedures in place to support employees with sickness absence and continues to develop a positive and pro-active approach in supporting employees through sickness absence or difficult periods in their lives. This has recently been evidenced by reviewing the Managing Sickness Absence Policy in not only aiming to reduce the levels of sickness through improvement plans but providing support mechanisms to employees during periods of short and long term sickness.

During 2015, the CCG introduced an Employee Assistance Programme (EAP) as part of its support for the workforce.

This service provides confidential advice and counselling support, providing an early source of practical and emotional support for employees facing issues in their home or work life. This is viewed by the CCG as being important in supporting the health and wellbeing of employees, as well as helping them to manage their work performance.

Throughout the winter period of 2017, the CCG offered workplace vaccinations to all its employees, in order to support the resilience of the workforce and the community. The winter 'flu campaign raised awareness of the benefits of the 'flu vaccination. The final uptake was 64%. The CCG also commissions a comprehensive Occupational Health service, providing expert advice and support in the management of health conditions at work.

The CCG is committed to the health and wellbeing of its staff and works hard to promote a healthy working environment. The Staff Forum has been proactive throughout the year in carrying out a number of initiatives, which are covered in more detail in the Sustainable Development Section of the Performance Report (see page 27).

The CCG engages with its staff through a variety of mechanisms, including an active staff forum, weekly updates with the Chief Officer, monthly staff workshops, and through the electronic staff newsletter. The CCG also participates annually in the national NHS Staff Survey in order to gain staff feedback and understand how the CCG benchmarks against other NHS organisations. 82.8% of staff responded to the survey in 2017. This is significantly higher than the national response rate of 45%. Overall, the CCG's results were positive, with an engagement index score of 3.97, compared with the national NHS score of 3.80. Particular highlights related to the organisation taking positive action on health and wellbeing, communication between senior managers, clarity of responsibilities, and acting on staff feedback. The results are being discussed with staff which will inform a development plan, focusing on strengths and areas for improvement.

5. Staff Policies

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

The CCG's commitment to recruitment, continuing employment, training and career development of disabled people is set out in a number of policies and procedures. These include:

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

➢ Policy review

The CCG has a rolling programme of policy review and awareness raising, as well as the appraisal procedure to further improve the focus on the quality of conversations taking place. The implementation of these policies together with occupational health input supports the continuation of employment and provision of appropriate training to any employee who becomes disabled and ensures access for all CCG employees, including disabled staff members to training, career development and promotion opportunities.

Equality impact assessments have been carried out on all the above policies. Over the past 12 months monitoring has taken place to ensure there has been no detrimental effect with regard to implementation of these workforce policies on CCG staff and to ensure that the CCG have proactively identified and addressed any inequalities.

➢ Disability Confident Employer

In 2016, the government made a commitment to halve the employment gap for disabled people and in order to achieve this it introduced a new Disability Confident scheme. We are extremely proud to say that our CCG was awarded the level 3 Disability Confident Employer badge for 2 years from August 2017. The award is based on us being able to demonstrate that we have:

- Undertaken and successfully completed the Disability Confident self-assessment;
- Are taking all of the core actions to be a Disability Confident employer;
- Are offering at least one activity to get the right people for the business and at least one activity to keeping and developing employees.

Armed Forces Employer Recognition Scheme (AFERS)

The Armed Forces Employer Recognition Award Scheme recognises the work carried out by organisations to support employment or services for the armed forces and veteran community.

The CCG was successful in achieving the Silver Award in October as a result of its work and policies for reservists. This included e-learning, community service engagement and having an armed forces champion.

As a Disability Confident Employer, we are able to use the logo which lets people know that we have made a commitment regarding recruitment, training, and retention of people with disabilities and the promotion of disability awareness across the organisation. We will continue to work to make this a welcoming and accessible place for people with a disability.

➢ Trade Union representation

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974. This information is provided below and can be found on the CCG's website.

Table 7: Relevant union officials during 2017-18

Total number of employees who were relevant union officials during the period of 1st April 2017 to 31st March 2018	1

Table 8 below, contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Table 8: Percentage time spent on facility time

Percentage of time spent	
0%	
1-50%	X
51-99%	
100%	

Note1: This data is in respect of the 1 member of staff.

Table 9: Percentage of pay bill spent on facility time

	£
Total cost of facility time	1,707
Total pay bill	4,304,000
% of total pay bill spent on facility time	0.04%

The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2017-18, on paid trade union activities.

Table 10: Paid Trade Union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours.	100%

Note1: Table 10 combines the percentage time spent on duties and activities for 2017-18. This figure will be separated out in 2018-19.

6. Expenditure on consultancy (2017-18)

Table 11: Expenditure on consultancy (2017-18)

Description	2017/18 Costs(£)
Salford Royal – RCRTRP Travel and Transport Consultancy	36,000
TOTAL	36,000

➢ **External Audit**

NHS Calderdale CCG has appointed KPMG as their external auditor for 2017-18. The cost of the work performed by the auditor in respect of the reporting period is £41,000 (excluding VAT):

Table 12: Services from KPMG (2017-18)

Services from KPMG	£
Audit Services Statutory audit and services carried out in relation to the statutory audit, e.g. reports to the Secretary of State	41,000
Further assurance services (i.e. any services unrelated to the statutory audit where the CCG has discretion whether or not to appoint an auditor (e.g. review of achievement of performance indicators)	0
Other Services	0
TOTAL	41,000

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.

7. Off-payroll Engagements

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

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

Table 13: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2018	2
Of which the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	1
For four or more years at the time of reporting	1

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

Table 14: New off-payroll engagements

For all new off-payroll engagements between 01 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to the entity) and are on the CCG payroll	0
Number of engagements re-assessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review.	0

Note: Under the reformed off-payroll working rules, Departments must determine whether the rules apply when engaging a worker through a Personal Service Company (PSC). Guidance and more information can be found here: Off-payroll working rules (IR35) for public authorities - GOV.UK

Table 15: Off-payroll engagements/senior official engagements

For any off-payroll engagements of Governing Body members and/or senior officials with significant financial responsibility - between 01 April 2017 and 31 March 2018.

	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.	0
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.	10

8. Exit Packages, including special (non-contractual) payments

There has been one exit package during 2017-18 (see table 16). There have been no other departures, requiring exit packages or severance payments.

Table 16: Exit Packages including special (non-contractual) payments (2017-18)

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000								
£10,000 - £25,000	**1**	**22,236**						
£25,001 - £50,000								
£50,001 - £100,000								
£100,001 - £150,000								
£150,001 – £200,000								
>£200,000								
TOTALS	**1**	**22,236**						

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where NHS Calderdale CCG has agreed early retirements, the additional costs are met by NHS Calderdale CCG and not by the NHS Pensions Scheme. Ill- health retirement costs are met by the NHS Pensions Scheme and are not included in the table. **Note:** The information in Table 16 is subject to audit by our external auditors KPMG LLP.

Dr Matt Walsh,
Accountable Officer,
24 May 2018

Parliamentary Accountability and Audit Report

NHS Calderdale CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities (see Financial Statements note 31), losses and special payments, gifts, and fees and charges (see Financial Statements note 40). An audit certificate and report is also included in this Annual Report at page 139.

NHS
Calderdale
Clinical Commissioning Group

NHS Calderdale Clinical Commissioning Group
Annual Accounts
2017-2018

FOREWORD TO THE ACCOUNTS

CALDERDALE CCG

These accounts for the year ended 31 March 2018 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 2017-18

CONTENTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(1,510)	(3,591)
Other operating income	2	(1,522)	(1,001)
Total operating income		**(3,032)**	**(4,592)**
Staff costs	4	5,074	4,696
Purchase of goods and services	5	312,886	311,468
Depreciation and impairment charges	5	82	72
Provision expense	5	0	0
Other Operating Expenditure	5	437	377
Total operating expenditure		**318,480**	**316,613**
Net Operating Expenditure		**315,447**	**312,021**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**315,447**	**312,021**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**315,447**	**312,021**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**315,447**	**312,021**

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	424	506
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		424	506
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	1,500	2,074
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	83	45
Total current assets		**1,583**	2,119
Non-current assets held for sale	21	0	0
Total current assets		**1,583**	2,119
Total assets		**2,007**	2,625
Current liabilities			
Trade and other payables	23	(23,791)	(20,099)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(23,791)**	(20,099)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(21,785)**	(17,475)
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		**(21,785)**	(17,475)
Financed by Taxpayers' Equity			
General fund		(21,785)	(17,475)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(21,785)**	(17,475)

The notes on pages 115 to 142 form part of this statement

The financial statements on pages 111 to 114 were approved by the Audit Committee on 17th May 2018 under delegated authority from the Governing Body and signed on its behalf by

Chief Accountable Officer
Dr. Matt Walsh

Statement of Changes In Taxpayers Equity for the year ended 31 March 2018

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(20,464)**	**0**	**0**	**(20,464)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(20,464)**	**0**	**0**	**(20,464)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(312,021)			(312,021)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(312,021)**	**0**	**0**	**(312,021)**
Net funding	315,010	0	0	315,010
Balance at 31 March 2017	**(17,475)**	**0**	**0**	**(17,475)**

The notes on pages 115 to 142 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(315,447)	(312,021)
Depreciation and amortisation	5	82	72
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	17	574	(1,036)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,692	(1,979)
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		**(311,099)**	(314,964)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(32)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	(32)
Net Cash Inflow (Outflow) before Financing		**(311,099)**	(314,996)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		311,137	315,010
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		**311,137**	315,010
Net Increase (Decrease) in Cash & Cash Equivalents	20	**38**	14
Cash & Cash Equivalents at the Beginning of the Financial Year		**45**	30
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		**83**	45

The notes on pages 115 to 142 form part of this statement

Notes to the financial statements

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis *[despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014].*
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

1.4 **Movement of Assets within the Department of Health and Social Care Group**

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

1.5 **Charitable Funds**

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

1.6 **Pooled Budgets**

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

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

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

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

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 Judgements during the period.

1.7.2 **Key Sources of Estimation Uncertainty**

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

1.8 **Revenue**

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 **Employee Benefits**

Notes to the financial statements

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

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 valuation.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

Notes to the financial statements

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

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

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 current value in existing use by reference to an active market, or, where no active market exists, at the lower of depreciated replacement cost or the value in use where the asset is income generating . Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

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.

Notes to the financial statements

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

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.17.2 **The Clinical Commissioning Group as Lessor**

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 **Private Finance Initiative Transactions**

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 **Services Received**

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

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**

Notes to the financial statements

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

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

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

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

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

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

1.22 **Clinical Negligence Costs**
The NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution 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 Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

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

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

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

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

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

Notes to the financial statements

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

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

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

1.26.4 **Loans & Receivables**
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.
If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

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

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

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

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

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

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

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

1.31 **Losses & Special Payments**

Notes to the financial statements

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

1.32 **Subsidiaries**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 **Associates**

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

1.34 **Joint Ventures**

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

1.35 **Joint Operations**

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

1.36 **Research & Development**

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

1.37 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year.

2 Other Operating Revenue

	2017-18 Total £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	771	611
Patient transport services	0	0
Prescription fees and charges	0	0
Dental fees and charges	0	0
Education, training and research	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	100
Receipt of donations for capital acquisitions: NHS Charity	0	0
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies*1	1,510	3,591
Continuing Health Care risk pool contributions	0	0
Income generation	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Non cash apprenticeship training grants revenue	0	0
Other revenue	751	290
Total other operating revenue	**3,032**	**4,592**

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

***1** Non-patient care services to other bodies includes £0.3K revenue received from Greater Huddersfield Clinical Commissioning Group for 2017/18 (£0.3K 2016/17)

3 Revenue

	2017-18 Total £'000	2016-17 Total £'000
From rendering of services	3,032	4,592
From sale of goods	0	0
Total	**3,032**	**4,592**

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

2017-18	Total		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	4,198	3,234	964
Social security costs	393	342	51
Employer Contributions to NHS Pension scheme	483	420	63
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**5,074**	**3,996**	**1,079**
Less recoveries in respect of employee benefits (note 4.1.2)	(771)	(771)	0
Total - Net admin employee benefits including capitalised costs	**4,304**	**3,225**	**1,079**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,304**	**3,225**	**1,079**

4.1.1 Employee benefits

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

4.1.2 Recoveries in respect of employee benefits

	2017-18			2016-17
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(624)	(624)	0	(496)
Social security costs	(65)	(65)	0	(53)
Employer contributions to the NHS Pension Scheme	(82)	(82)	0	(62)
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	**(771)**	**(771)**	**0**	**(611)**

4.2 Average number of people employed

	2017-18 Total Number	2017-18 Permanently employed Number	2017-18 Other Number	2016-17 Total Number
Total	**85**	**70**	**15**	**79**
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

	2017-18 Number	2016-17 Number
Total Days Lost	1,038	678
Total Staff Years	90	81
Average working Days Lost	12	8

	2017-18 Number	2016-17 Number
Number of persons retired early on ill health grounds	0	0
	£'000	**£'000**
Total additional Pensions liabilities accrued in the year	0	0

The staff sickness absence statistics relate to the calendar year (January to December 2017).

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

4.4 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	1	22,236	1	22,236
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**1**	**22,236**	**1**	**22,236**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2017-18 Other agreed departures		2016-17 Other agreed departures	
	Number	**£**	**Number**	**£**
Voluntary redundancies including early retirement contractual costs	1	22,236	0	0
Mutually agreed resignations (MARS) contractual costs	0	-	0	0
Early retirements in the efficiency of the service contractual costs	0	-	0	0
Contractual payments in lieu of notice	0	-	0	0
Exit payments following Employment Tribunals or court orders	0	-	0	0
Non-contractual payments requiring HMT approval*	0	-	0	0
Total	**1**	**22,236**	**0**	**0**

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

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

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

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 date 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers' contributions of £421k were payable to the NHS Pensions Scheme (2016-17: £430K) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2017-18 Total £'000	2016-17 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	4,765	4,347
Executive governing body members	309	349
Total gross employee benefits	**5,074**	**4,696**
Other costs		
Services from other CCGs and NHS England	280	294
Services from foundation trusts	166,760	169,420
Services from other NHS trusts	19,980	19,841
Sustainability Transformation Fund	0	0
Services from other WGA bodies	0	19
Purchase of healthcare from non-NHS bodies	54,361	51,497
Purchase of social care	0	0
Chair and Non Executive Members	437	377
Supplies and services – clinical	4	3
Supplies and services – general	352	435
Consultancy services	36	84
Establishment	1,375	1,245
Transport	1	2
Premises	1,936	1,701
Impairments and reversals of receivables	0	0
Inventories written down and consumed	0	0
Depreciation	82	72
Amortisation	0	0
Impairments and reversals of property, plant and equipment	0	0
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets		
· Assets carried at amortised cost	0	0
· Assets carried at cost	0	0
· Available for sale financial assets	0	0
Impairments and reversals of non-current assets held for sale	0	0
Impairments and reversals of investment properties	0	0
Audit fees	52	55
Other non statutory audit expenditure		
· Internal audit services ***1**	0	0
· Other services	0	0
General dental services and personal dental services	0	0
Prescribing costs	37,447	37,626
Pharmaceutical services	0	0
General ophthalmic services	170	127
GPMS/APMS and PCTMS ***2**	29,961	28,696
Other professional fees excl. audit	41	191
Legal fees	93	0
Grants to Other bodies	0	0
Clinical negligence	0	0
Research and development (excluding staff costs)	0	0
Education and training	36	50
Change in discount rate	0	0
Provisions	0	0
Funding to group bodies	0	0
CHC Risk Pool contributions	0	182
Non cash apprenticeship training grants	0	0
Other expenditure	0	0
Total other costs	**313,405**	**311,917**
Total operating expenses	**318,479**	**316,613**

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 £41K 2017-2018 (2016-2017 £40k) are included in Services from Foundation Trusts.
***2** GPMS/APMS and PCTMS included £27.946m for delegated responsibility for commissioning Primary Medical Services for 2017/18 (£27.174m in 2016/17).

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,128	83,830	10,554	86,505
Total Non-NHS Trade Invoices paid within target	9,084	82,903	10,508	86,238
Percentage of Non-NHS Trade invoices paid within target	**99.52%**	**98.89%**	**99.56%**	**99.69%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,618	190,444	2,603	191,359
Total NHS Trade Invoices Paid within target	2,575	190,431	2,489	190,847
Percentage of NHS Trade Invoices paid within target	**98.36%**	**99.99%**	**95.62%**	**99.73%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2017-18 £'000**	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

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

8. Investment revenue

The Clinical Commissioning Group does not have any investment revenue.

9. Other gains and losses

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

10. Finance costs

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

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

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

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	1,318	0	**1,318**	0	1,194	(4)	**1,190**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**1,318**	**0**	**1,318**	**0**	**1,194**	**(4)**	**1,190**

The lease payment above include £216k for NHS Property Services, in 2016/17 the equivalent amount was £217k.

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	Buildings £'000	Other £'000	Total £'000	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	736	0	**736**	0	845	-	**845**
Between one and five years	0	2,947	0	**2,947**	0	2,947	-	**2,947**
After five years	0	4,914	0	**4,914**	0	5,652	-	**5,652**
Total	**0**	**8,597**	**0**	**8,597**	**0**	**9,444**	**0**	**9,444**

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

2017-18	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2017	0	0	0	0	0	0	138	700	837
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**138**	**700**	**837**
Depreciation 01 April 2017	0	0	0	0	0	0	85	247	332
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	25	57	82
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**110**	**305**	**414**
Net Book Value at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**28**	**395**	**423**
Purchased	0	0	0	0	0	0	29	395	424
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**395**	**424**
Asset financing:									
Owned	0	0	0	0	0	0	29	395	424
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**29**	**395**	**424**

Revaluation Reserve Balance for Property, Plant & Equipment

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

2016-17	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	0	0	0	0	0	0	107	700	807
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	31	0	31
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**138**	**700**	**838**
Depreciation 01 April 2016	0	0	0	0	0	0	70	190	260
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	14	57	72
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**85**	**247**	**332**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**53**	**452**	**506**
Purchased	0	0	0	0	0	0	54	452	506
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**452**	**506**
Asset financing:									
Owned	0	0	0	0	0	0	54	452	506
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**54**	**452**	**506**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 01 April 2016	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The Clinical Commissioning Group do not have any assets under construction.

13.2 Donated assets

The Clinical Commissioning Group do not have donated assets.

13.3 Government granted assets

The Clinical Commissioning Group do not have government granted assets.

13.4 Property revaluation

The Clinical Commissioning Group do not have any properties.

13.5 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

13.6 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

13.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

13.8 Cost or valuation of fully depreciated assets

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

	2017-18 £'000	2016-17 £'000
Information technology	78	52
Furniture & fittings	0	0
Total	**78**	**52**

13.9 Economic lives

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

14 Intangible non-current assets

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

14.1 Donated assets

The Clinical Commissioning Group do not have any donated assets.

14.2 Government granted assets

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

14.3 Revaluation

The Clinical Commissioning Group do not have any properties.

14.4 Compensation from third parties

Not applicable to Calderdale Clinical Commissioning Group.

14.5 Write downs to recoverable amount

Not applicable to Calderdale Clinical Commissioning Group.

14.6 Non-capitalised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.7 Temporarily idle assets

Not applicable to Calderdale Clinical Commissioning Group.

14.8 Cost or valuation of fully amortised assets

Not applicable to Calderdale Clinical Commissioning Group.

14.9 Economic lives

Not applicable to Calderdale Clinical Commissioning Group.

15 Investment property

The Clinical Commissioning Group has no investment property at 31st March 2018.

16 Inventories

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

17 Trade and other receivables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	539	0	189	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	0	0	0	0
NHS accrued income	41	0	755	0
Non-NHS and Other WGA receivables: Revenue	744	0	943	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	163	0	170	0
Non-NHS and Other WGA accrued income	0	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	13	0	17	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	0	0
Total Trade & other receivables	**1,500**	**0**	**2,074**	**0**
Total current and non current	**1,500**		**2,074**	
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	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
By up to three months	532	86	984
By three to six months	7	0	15
By more than six months	0	0	0
Total	**539**	**86**	**999**

£547k of the amount above has subsequently been recovered post the statement of financial position date 18.04.18.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2018.

17.2 Provision for impairment of receivables	2017-18 £'000 DH Group Bodies	2017-18 £'000 Group Bodies	2016-17 £'000 All receivables prior years
Balance at 01 April 2017	0	0	0
Amounts written off during the year	0	0	0
Amounts recovered during the year	0	0	0
(Increase) decrease in receivables impaired	0	0	0
Transfer (to) from other public sector body	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**

18 Other financial assets

18.1 Current

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

18.2 Non-current

The Clinical Commissioning Group has no non-current assets as at 31st March 2018.

18.3 Non-current: capital analysis

The Clinical Commissioning Group has no non-current capital as at 31st March 2018.

19 Other Current assets

The Clinical Commissioning Group have no other current assets as at 31st March 2018.

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	45	30
Net change in year	38	14
Balance at 31 March 2018	**83**	**45**
Made up of:		
Cash with the Government Banking Service	83	45
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	**83**	**45**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**83**	**45**

The Clinical Commissioning Group have no bank overdraft as at 31 March 2018.

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 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	706	0	2,530	0
NHS payables: capital	0	0	0	0
NHS accruals	1,548	0	1,589	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	11,672	0	7,629	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	9,481	0	7,967	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	58	0	51	0
VAT	0	0	0	0
Tax	42	0	42	0
Payments received on account	0	0	0	0
Other payables and accruals	284	0	291	0
Total Trade & Other Payables	**23,791**	**0**	**20,099**	**0**
Total current and non-current	**23,791**		**20,099**	

The CCG has no liabilities for early retirement.

Other payables include £119k outstanding pension contributions at 31 March 2017

24 Other financial liabilities

The Clinical Commissioning Group has no other financial liabilities as at 31st March 2018.

25 Other liabilities

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

26 Borrowings

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

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group has no private finance initiative, LIFT or other service concession arrangements as at 31st March 2018.

28 Finance lease obligations

The Clinical Commissioning Group has no financial lease obligations as at 31st March 2018.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31st March 2018.

30 Provisions

	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'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 2018 is £75,811. (2016/17 £234,000).

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

	2017-18 £'000	2016-17 £'000
Contingent liabilities		
Equal Pay	0	0
NHS Resolution Legal Claims	0	0
Employment Tribunal	0	0
NHS Resolution 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		
Amount Payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

	2017-18 £'000	2016-17 £'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:

	2017-18 £'000	2016-17 £'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 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' 2017-18 £'000	Loans and Receivables 2017-18 £'000	Available for Sale 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	580	0	580
· Non-NHS	0	744	0	744
Cash at bank and in hand	0	83	0	83
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**1,406**	**0**	**1,406**

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

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	Other 2017-18 £'000	Total 2017-18 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,254	2,254
· Non-NHS	0	21,437	21,437
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 2018	**0**	**23,692**	**23,692**

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

33.4 Maturity of financial liabilities

	Payable to DH 2017-18 £000	Payables to Other Bodies 2017-18 £000	Total 2017-18 £000	Payable to DH 2016-17 £000	Payables to Other Bodies 2016-17 £000
In one year or less	0	23,692	23,692	0	20,007
In more than one year but not more than two years	0	0	0	0	0
In more than two years but not more than five years	0	0	0	0	0
In more than five years	0	0	0	0	0
Total CCG at 31 March 2018	0	23,692	23,692	0	20,007

33.5 CCG's exposure to risk

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

34 Operating segments

The Clinical Commissioning Group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2017-18 £'000	2016-17 £'000
Total net expenditure reported for operating segments	315,447	312,021
Reconciling items:		
Total net expenditure per the Statement of Comprehensive Net Expenditure	315,447	312,021

34.2 Reconciliation between Operating Assets and SoFP

	2017-18 £'000	2016-17 £'000
Total assets reported for operating segments	2,007	2,625
Reconciling items:		
Total assets per the Statement of Financial Position	2,007	2,625

34.3 Reconciliation between Operating Liabilities and SoFP

	2017-18 £'000	2016-17 £'000
Total liabilities reported for operating segments	(23,791)	(20,099)
Reconciling items:		
Total liabilities per Statement of Financial Position	(23,791)	(20,099)

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.

The Better Care Fund is a mandatory policy to facilitate integration of service provision between Health and Social Care. The schemes managed through the BCF include : Disabled Facilities Grants, carers services, supporting social care, reablement and recovery services. Under the policy we have to report on a number of metrics which include delayed discharges from hospital and levels of emergency admissions.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006. The pooled budget is jointly controlled between the CCG and Calderdale Metropolitan Borough Council.

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

	2017-18 £000	2016-17 £000
Income		
Calderdale Clinical Commissioning Group	13,973	13,728
Calderdale Metropolitan Borough Council	2,270	2,063
Total Income	**16,243**	**15,791**
Expenditure		
Calderdale Clinical Commissioning Group	13,972	13,725
Calderdale Metropolitan Borough Council	2,270	2,063
Total Expenditure	**16,242**	**15,788**

The NHS Clinical Commissioning Group has £2,562k of payables relating to the Better Care Fund as at 31st March 2018.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Related party transactions

NHS Calderdale Clinical Commissioning Group is a body corporate established by order of the Secretary of State for Health.
During the year none of the Department of Health Ministers, Board Members or members of the key management staff or parties to them has undertaken any material transactions with NHS Calderdale CCG.

In accordance with the requirements of the Accounts any transactions with General Practise for which Governing Body members have a relationship have been disclosed below. In 2016/17 these payments included the payments to practices for providing Primary Medical Care services as these were delegated to the CCG in this financial year.

Payments to Practices of Governing Body members :

	2017-18				2016-17			
	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
GOVERNING BODY MEMBERS :								
Longroyde Surgery (Dr Alan Brook)	428	0	0	0	409	0	2	0
Spring Hall Group Practice (Dr Steven Cleasby)	1,213	0	0	0	1,370	0	11	0
Southowram Surgery (Dr Majid Azeb)	369	0	0	0	375	0	5	0
Hebden Bridge Group Practice (Dr Nigel Taylor & Dr H Davies)	2,483	0	0	0	2,462	0	0	0
Beechwood Medical Centre (Dr Caroline Taylor)	1,136	0	0	0	1,105	0	0	0
Rastrick Health centre (Dr F Javid)	573	0	0	0	0	0	0	0
Rosegarth Surgery	1,228	0	0	0	1,138	0	0	0

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

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

David Longstaff is the audit lay member for Calderdale CCG, Greater Huddersfield CCG and North Kirklees CCG , but had no material transactions.

In addition the executive Governing Body members have relatives or interests with the following organisations :
Calderdale and Huddersfield NHSFT,
Calderdale MBC,
Bradford Teaching Hospitals NHS FT
East Lancashire NHS T
Pennine Acute NHST.
Leeds Teaching Hospitals NHS Trust
Insight
Age UK
Rosegarth Surgery

Two Governing Body members also have material transactions with:
Barnsley Hospital NHS FT
The Christie NHS FT

And material transactions are detailed below :

The Department of Health and NHS England are regarded as a related party. NHS England is the parent entity and the Department of Health is regarded as the parent department. During the year the clinical commissioning group has had a significant number of material transactions with the Department of Health. For example expenditure made to these bodies:

	2017/18 £000	2016/17 £000
Calderdale and Huddersfield NHSFT	139,434	143,067
South West Yorkshire Partnership NHSFT	20,687	19,868
Yorkshire Ambulance NHS Trust	11,945	11,462
Leeds Teachings Hospitals NHST	5,763	5,911
Bradford Teachings Hospitals NHSFT	3,661	4,143
NHS Greater Huddersfield CCG	674	648
Pennine Acute NHST	637	583
East Lancashire Hospital NHS Trust	650	723
Mid Yorkshire Hospitals NHS Trust	600	819
Central Manchester University NHS FT	209	450
CSU	253	2
The Christie NHS FT	67	16
Calderdale Local Medical Committee	77	31
NHS North Kirklees CCG	19	18

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies.

	2017/18 £000	2016/17 £000
Calderdale MBC	17,200	16,971

38 Events after the end of the reporting period

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

39 Third party assets

The Clinical Commissioning Group held no cash and cash equivalents which relate to monies held by the Clinical Commissioning Group.

40 Losses and special payments

The Clinical Commissioning Group has no losses or special payments

41 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2017-18 Target £'000	2017-18 Performance £'000	2017-18 Duty Achieved	2016-17 Target £'000	2016-17 Performance £'000	2016-17 Duty Achieved
Expenditure not to exceed income	318,479	318,479	Yes	322,476	316,645	Yes
Capital resource use does not exceed the amount specified in Directions	0	0	Yes	80	32	Yes
Revenue resource use does not exceed the amount specified in Directions	315,447	315,447	Yes	317,804	312,021	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	80	32	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	4,666	4,474	Yes	4,670	4,301	Yes

The CCG received total revenue resource allocation of £319,990K and had net expenditure of £315,447K delivering an agreed surplus of £4,552K.

42 Impact of IFRS

Not applicable to Calderdale Clinical Commissioning Group.

43 Analysis of charitable reserves

Not applicable to Calderdale Clinical Commissioning Group.

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Calderdale Clinical Commissioning Group ("the CCG") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health & Social Care Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health & Social Care Group Accounting Manual 2017/18.

KPMG

Accountable Officer's responsibilities

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on pages 46 and 47, the Accountable Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCGs ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

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

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the Statement of Accountable Officer's Responsibilities set out on page 46 and 47, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice ') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG , is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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

Timothy Cutler
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 St Peter's Square
Manchester
M23AE

25 May 2018

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