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Wednesday 22 June 2016

Notice of Meeting

Dear Member

Health and Wellbeing Board

The **Health and Wellbeing Board** will meet in the **Reception Room - Town Hall, Huddersfield** at **2.00 pm** on **Thursday 30 June 2016.**

The items which will be discussed are described in the agenda and there are reports attached which give more details.

Julie Muscroft

Assistant Director of Legal, Governance and Monitoring

Kirklees Council advocates openness and transparency as part of its democratic processes. Anyone wishing to record (film or audio) the public parts of the meeting should inform the Chair/Clerk of their intentions prior to the meeting.

The Health and Wellbeing Board Members are:-

Councillor Kath Pinnock
Councillor Donna Bellamy
Rory Deighton
Dr David Kelly
Carol McKenna
Dr Steve Ollerton
Richard Parry
Rachel Spencer-Henshall
Fatima Khan-Shah
Sarah Callaghan

Agenda
Reports or Explanatory Notes Attached

Pages

1: Appointment of Chair

The Board will appoint a chair for the meeting.

Contact: Jenny Bryce-Chan, Tel: 01484 221000

2: Membership of the Board/Apologies

This is where members who are attending as substitutes will say for whom they are attending.

Contact: Jenny Bryce-Chan, Tel: 01484 221000

3: Minutes of previous meeting — 1 - 8

To approve the minutes of the meeting of the Board held on 28 April 2016.

Jenny Bryce-Chan, Tel: 01484 221000

4: Interests — 9 - 10

The Board Members will be asked to say if there are any items on the Agenda in which they have disclosable pecuniary interests, which would prevent them from participating in any discussion of the items or participating in any vote upon the items, or any other interest.

5: Admission of the Public

Most debates take place in public. This only changes when there is a need to consider certain issues, for instance, commercially sensitive information or details concerning an individual. You will be told at this point whether there are any items on the Agenda which are to be discussed in private.

6: Deputations/Petitions

The Board will receive any petitions and hear any deputations from members of the public. A deputation is where up to five people can attend the meeting and make a presentation on some particular issue of concern. A member of the public can also hand in a petition at the meeting but that petition should relate to something on which the body has powers and responsibilities.

7: Public Question Time

The Board will hear any questions from the general public.

MATTERS FOR CONSIDERATION

8: Kirklees Joint Strategic Assessment

11 - 38

To share the new ‘Kirklees Overview’ 2016 with the Board to coincide with the ‘launch’ of the new Kirklees Joint Strategic Assessment.

Contact: Sarah Muckle, Consultant in Public Health Tel: 01484 221000

9: Sustainability and Transformation Plan

39 - 44

To provide the Board with an update on progress with developing the Sustainability and Transformation Plan (STP), particularly the Healthy Futures component and the feedback from the Scenario Planning event held on 26th April 2016.

Contact: Contact: Phil Longworth, Health Policy Officer, Rachel Millson, Business Planning Manager and Natalie Ackroyd, Business Performance Reporting and Planning Manager

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10: Healthy Child Programme

45 - 54

To update the Board on progress with developing the Healthy Child Programme (HCP) 0-19 as a key part of the activity aiming to transform services for children and young people.

Contact: Keith Henshall, Head of Health Improvement Tel: 01484 221000, Tom Brailsford, Joint Commissioning Manager

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11: A Community Wellness Model of Health Improvement for Kirklees

55 - 62

To outline emerging plans to move towards commissioning an integrated wellness model of health improvement focused on integration and system change.

Contact: Tony Cooke, Head of Health Improvement, Tel: 01484 221000

12: Health Protection Board Update

63 - 66

To update the Health and Wellbeing Board on the work of its subcommittee the Health Protection Board.

Contact: Mercy Vergis, Consultant in Public Health Medicine, Tel: 01484 221000

13: Health and Wellbeing Board Position Statement Re: Service Changes

67 - 70

To seek the Board's approval of the attached Position Statement with regard to 'Proposals for major health and social service changes affecting Kirklees'.

Contact: Phil Longworth, Health Policy Officer Tel: 01484 221000

14: Better Care Fund

To provide a verbal update on the Better Care Fund.

Contact: Phil Longworth, Health Policy Officer, Tel: 01484 221000

15: Re-establishment of the CSE Safeguarding Member Panel for 2016/17 Municipal year

71 - 74

To seek Health and Wellbeing Board's formal agreement for the re-establishment of the Child Sexual Exploitation and Safeguarding Member Panel for the 2016/17 Municipal Year and agree the Kirklees Council representation on the Panel.

Contact: Helen Kilroy, Principal Governance Officer Tel: 01484 221000

TO NOTE

16: North Kirklees Clinical Commissioning Group - Annual Report

75 - 184

For the Board to note the North Kirklees Clinical Commissioning Group's Annual Report.

Contact: Rachel Millson, Business Planning Manager

17: Greater Huddersfield Clinical Commissioning Group Operational Plan

185 - 218

For the Board to note the Greater Huddersfield Clinical Commissioning Group Operational Plan.

Contact: Natalie Ackroyd, Business Performance Reporting and Planning Manager.

18: Date of Next Meeting

To note that the next meeting of the Health and Wellbeing Board will be on the 28th July 2016, Council Chamber, Dewsbury Town Hall.

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Contact Officer: Jenny Bryce-Chan

KIRKLEES COUNCIL

HEALTH AND WELLBEING BOARD

Thursday 28th April 2016

Present:

Councillor Donna Bellamy
Kiran Bali
Carol McKenna
Richard Parry
Rachel Spencer-Henshall
Sarah Callaghan

Apologies:

Councillor Viv Kendrick (Chair)
Councillor Jean Calvert
Councillor Erin Hill
Councillor Kath Pinnock
Rory Deighton
Dr David Kelly
Dr Steve Ollerton

In attendance:

Observers:

117 Appointment of Chair

Councillor Donna Bellamy was appointed chair of the meeting.

118 Membership of the Board/Apologies

The Board noted the following substitutions:

Fatima Khan-Shah for Rory Deighton
Dr Nadeem Ghafoor for Dr David Kelly
Catherine Riley for Owen Williams
Karen Taylor for Alex Farrell
Matt England for Michael Barkley

Apologies for absence were received from: Cllr Viv Kendrick, Cllr Jean Calvert, Cllr Erin Hill, Cllr Kath Pinnock, Dr David Kelly, Dr Steve Ollerton, Rory Deighton and Chief Superintendent Steve Cotter.

119 Minutes of previous meeting

RESOLVED – That the minutes of the meeting held on the 31 March 2016 be agreed as a correct record.

120 Interests

No interests were declared.

121 Admission of the Public

All agenda items were considered in public session.

122 Deputations/Petitions

No deputations or petitions were received.

123 Primary Care Strategy

Jan Giles and Jackie Holdich attended the meeting to present the Primary Care Strategies for Greater Huddersfield CCG and North Kirklees CCG.

The Board was advised that the strategies affects Kirklees residents as a whole and the overall vision for healthcare is that it is high quality supportive, proactive accessible to all and delivered in a safe and cost effect way. The vision has been developed in conjunction with a number of other strategies and NHS England published its forward view nationally and Kirklees is in line with the national picture.

The Board was informed that the process for developing the strategies had included extensive engagement with patients, representative patient bodies, public, partners, stakeholders, GP's and clinical leaders to focus on what is necessary, realistic and achievable.

The key outcomes are that healthcare offers seamless, integrated care to all patients which focuses on access, quality, workforce, premises and infrastructure and funding and contracting. Working groups have been established with project plans and the governance structures are in place for reporting purposes.

The Board was advised that forward planning is important because of the aging workforce and work is being done to look at a different workforce with different and more flexible ways of working for general practice.

The Board commented that it is important for the Health and Wellbeing Board take a lead role in developing a collaborative workforce strategy across both health and social care that ensures the appropriate workforce for the future.

RESOLVED - That receipt of the Primary Care Strategies for Greater Huddersfield and North Kirklees CCG's be noted by the Board.

124 Care Home Strategy

Phil Longworth presented the Care Home Strategy, advising the Board that the strategy had been jointly developed between Kirklees Council, North Kirklees and Greater Huddersfield CCGs. The strategy outlines the shared approach that partner organisations will take with regard to the ongoing development of care homes for older people in Kirklees.

The Board was informed that the strategy highlights issues that need to be addressed such as the difficulty recruiting and retaining of care workers and managers. The workforce challenge in the care home sector is significant therefore the actions to address this must be a major element of the delivery plan.

Developing a suitably skilled workforce will require consideration being given to professional development for managers and continuing development of care home staff.

The Board was informed that the strategy aims to ensure that the people living in care homes have a positive experience and to ensure that all homes are:

1) A good place to live
2) An effective part of a wider system that supports older people
3) A successful business

The Board discussed the need to develop a 'place based' view of health and social care services, including how the care homes in an area link with the primary care services. Given the importance of care homes to the sustainability of the health and social care system it is important to be clear about who is driving the strategy on behalf of the partners and how it can be driven at pace. Work still needs to be done on how to measure the outcomes of the strategy using a set of indicators for Kirklees

The Board commented that it was keen to support discussions with the CQC about the system level risks that result from inspections.

RESOLVED -
(a) That the content of the Strategy be noted.
(b) That the Strategy be endorsed by all partners.
(c) That all partners consider their roles in delivering the action plan within the Strategy.

125 Sustainability Transformation Plan update

Rachel Millson attended the meeting to provide a progress update on the Sustainability and Transformation Plan (STP). The Board was advised that there had been a discussion at Chief Officers Group with regard to the checklist requirements and what should be included in the plan. Carol McKenna has been identified as the Senior Responsible Officer for overseeing the development of the local plan.

The Board was informed that the month of April was used for collecting information in response to the guidelines received so far and deciding what will need to be in the STP based on 10 big questions that need to adequately addressed. The requirements from NHS England are very prescriptive and further guidance and direction from NHS England is awaited. At this stage it is not clear if there will be a template for submitting the information on.

The first checkpoint submission was made on the 15 April 2016, and will give an indication of thinking in readiness for preparing the STP which needs to be completed and submitted on the 30 June 2016. The intention is to have a draft prepared by the end of May.

The Board was informed that work had been done to try and identify the challenges and workforce is definitely a challenge however the STP provides an opportunity to

come up with a workforce plan. NHS England will be looking at the STP having a workforce plan as it is a national issue.

Work has been undertaken to introduce the STP as a concept to GP community in North Kirklees and also to develop a communication and engagement plan and engagement will not cease once the plan has been submitted. There is still more work that needs to be done however much progress has been made.

The Board was advised that areas that still need to be considered are the 3 gaps and there has been some discussion about how to address the funding and efficiency gap and this discussion will be opened up. It will be important to consider how to understand the collective financial position and what the system pressure looks like and coming to a financial truth. Currently transformation streams have money attached with money coming through STP therefore it is also important to identify areas of commonality.

Work is progressing across West Yorkshire by the Healthy Futures PMO. Workshops have been held across the 4 priority areas to discuss opportunities for joint working and agree the underpinning programmes and timescales.

A number of different organisations have come forward to support the development of the STP and are working through how best to access and utilise this. Public Health England have produced a ‘state of the region’ report which is currently with Kirklees Public Health for local interpretation and consideration in the STP development process. This work will link to the refresh of the Joint Strategic Assessment.

RESOLVED - That the update on the STP be received and noted by the Board.

126 Integrated Front Door Proposal (Multi-Agency Safeguarding Hub)

Trish Berry attended the meeting to advise the Board on the proposals to remodel the Multi-Agency Safeguarding Hub (MASH). The Board was informed that the MASH has been in place in Kirklees, since 2015 and consists of co-located professionals from health, education, police and children’s social care.

Recent audit work had identified the need to strengthen the offer at the front door as the Kirklees offer is limited. Proposals to strengthen the MASH will include links to a larger network of agencies to improve information sharing and it has been difficult to deploy staff to deal with issues as there has not been the breath of agencies involved. There are financial benefits to having the right agencies at the front door. Improvements to the MASH will also include:

- An additional detective sergeant at the front door
- Early help at the front door for families to stop cases escalating and to have the key people to deal with cases of child Sexual Exploitation, Keeping children safe
- Record and information sharing agreement currently in place extended to cover new agencies that come into the MASH
- Seamless approach to MASH will include technology

The Council will look to accommodate the MASH.

RESOLVED - That the suggested model for the Multi-Agency Safeguarding Hub be agreed.

127 Transforming Care Partnership Plan

Kelly Glover attended the meeting to present the draft Transforming Care Partnership Plan. The Board was advised that Calderdale, Kirklees, Wakefield and Barnsley (CKWB) had worked collaboratively to develop a programme that will transform community infrastructures and reshape services for people with a learning disability and or autism. NHS England requires that the plan is co-produced.

The Board was informed that the CKWB region was rated 6th highest for CCG commissioned in-patient beds and although work has been ongoing to reduce the numbers, the region is still well over the national planning assumptions for in-patient beds.

The plan is continually being developed and the final submission to NHS England will be on the 1 July 2016 with checkpoints on the 20 May and 24 June. NHS England have set an assessment framework.

The plan will be further developed with key stakeholders to ensure true co-production and an engagement event had been planned for the 25 May.

RESOLVED -

(a) That the plan be received and noted

(b) That the Board endorses and supports the Transformation Care Partnership Plan

128 Special Educational Needs and Disability Ofsted Inspections

Mandy Cameron, Deputy Assistant Director, Learning and Skills advised the Board that from the 1 May 2016 Ofsted will begin their timetable to carry out an area Special Education Needs and Disability (SEND) inspection. Every area will be subject to an inspection within the next 5 years.

The Board was informed that the framework for the inspection had only just been released however early guidance suggests that a wide range of information will be used in the evaluation process alongside methods to gather the views of identified children and young people, parents and carers, leaders with the local area and providers. In Kirklees there are 5000 Special Education Needs and 1800 Education Health Care Plans.

The inspection will be far reaching and will look at the Joint Strategic Needs Assessment outcomes, Joint Health and Wellbeing Strategy, performance data published by the Department for Education and Department of Health, Healthy Child Programme, School Nursing Service, health services pathways, neonatal screening programme and the CAMHS Transformation plan. The fieldwork will include discussions with elected members, key local area officers from health, education

and social care. Initial discussions will take place with the DCS and the Chief Executive of the CCGs.

The inspection team which will include an HMI (lead) a CQC inspector and a Local Authority inspector will ring up 5 days prior to the start of the inspection, which will last 5 days or longer depending on the complexity and will focus on:
- An evaluation of how effectively the local area identifies disabled children and young people and those who have special educational needs.
- An evaluation of how effectively the local area meets the needs and improves the outcomes of disabled children and young people and those who have special educational needs.

The inspection will only be carried out in term time and will speak to the people identified. The team will be checking to see if the provision is adequate to meet need. Briefings have stressed that inspectors will be checking whether the area provides for disabled CYP to the detriment of those with SEN.

In order for Kirklees to respond to the inspection, all key partners must understand what will be required of them during this process and a series of briefings will be organised, with invitations for key officers.

With regard to the judgement criteria there is no grade. The Council will receive a narrative outlining strengths and weaknesses. There may be a requirement to draw up an action plan, and this would lead to further, ongoing contact with inspectors.

RESOLVED - That Members of the Board share the information with their respective organisations and prepare themselves for the inspection.

129 Health and Wellbeing Board Terms of Reference

Phil Longworth informed the Board that the proposed revision to the terms of reference for the Health and Wellbeing Board was an outcome of the Board's development session in September 2015. One of the outputs from the session was that the Board would clarify and improve understanding of its role and purpose.

The Board was advised that the proposed revisions were intended to reflect the outputs from the session and the Board was asked to consider and agree the revisions.

RESOLVED - That the revisions to the terms of reference be agreed by the Board.

130 North Kirklees Clinical Commissioning Group Operational Plan

The Board considered the North Kirklees Operational Plan.

RESOLVED - That the Plan be received and noted by the Board.

131 Minutes of CSE & Safeguarding Member Panel

The Board considered the minutes of the Child Sexual Exploitation and Safeguarding Panel held on the 3 March 2016.

RESOLVED - That the Minutes be received and noted by the Board.

132 Date of next meeting

RESOLVED - That the date of the next meeting be noted.

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KIRKLEES COUNCIL

COUNCIL/CABINET/COMMITTEE MEETINGS ETC
DECLARATION OF INTERESTS

HEALTH AND WELL BEING BOARD

Name of Councillor

Item in which you have an interest	Type of interest (eg a disclosable pecuniary interest or an "Other Interest")	Does the nature of the interest require you to withdraw from the meeting while the item in which you have an interest is under consideration? [Y/N]	Brief description of your interest

Signed: ………………………………………… **Dated:** ……………………………………..

NOTES

Disclosable Pecuniary Interests

If you have any of the following pecuniary interests, they are your disclosable pecuniary interests under the new national rules. Any reference to spouse or civil partner includes any person with whom you are living as husband or wife, or as if they were your civil partner.

Any employment, office, trade, profession or vocation carried on for profit or gain, which you, or your spouse or civil partner, undertakes.

Any payment or provision of any other financial benefit (other than from your council or authority) made or provided within the relevant period in respect of any expenses incurred by you in carrying out duties as a member, or towards your election expenses.

Any contract which is made between you, or your spouse or your civil partner (or a body in which you, or your spouse or your civil partner, has a beneficial interest) and your council or authority -

- under which goods or services are to be provided or works are to be executed; and
- which has not been fully discharged.

Any beneficial interest in land which you, or your spouse or your civil partner, have and which is within the area of your council or authority.

Any licence (alone or jointly with others) which you, or your spouse or your civil partner, holds to occupy land in the area of your council or authority for a month or longer.

Any tenancy where (to your knowledge) - the landlord is your council or authority; and the tenant is a body in which you, or your spouse or your civil partner, has a beneficial interest.

Any beneficial interest which you, or your spouse or your civil partner has in securities of a body where -
(a) that body (to your knowledge) has a place of business or land in the area of your council or authority; and
(b) either -

the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or
if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which you, or your spouse or your civil partner, has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**30 June 2016**
TITLE OF PAPER:	**Kirklees Joint Strategic Assessment (KJSA) Overview 2016**

1. Purpose of paper

To share the new 'Kirklees Overview' 2016 (slides attached) with the Board to coincide with the 'launch' of the new Kirklees Joint Strategic Assess (KJSA) website - . This overview summarises the key population health and wellbeing challenges for Kirklees and provides a useful context for the more detailed JSA sections being updated during 2016.

2. Background

In February 2015 the Board endorsed a new approach to JSNA development - an ongoing process focussed on both needs and assets which outlines medium and longer term challenges for the district. Subsequent papers have updated on the progress of the KJSA steering group, the KJSA updating process and schedule and the development of the new KJSA website.

The Kirklees Overview provides a context for the more detailed sections of the KJSA and summarises the 'big issues' and 'key challenges' for health and wellbeing using infographics and simple messages.

Not all data in the Kirklees Overview and the other KJSA sections is new data. Intelligence derived from population surveys (children's and adults) on a 2 yearly cycle will be used to update the relevant sections. For example, intelligence from the Children and Young People's survey 2014 is supporting the update of all relevant sections and new intelligence from the forthcoming CLiK 2016 survey will be used to update all sections on adult health and wellbeing. New data, intelligence and insight from other sources will be incorporated as and when it becomes available.

3. Proposal

The Board is asked to endorse and support the Kirklees Overview 2016 and the overall approach to developing the KJSA to ensure that the JHWS is driven by appropriate, meaningful and timely intelligence. The Kirklees Overview will be updated annually and published on-line following approval from the Board. Together with the more detailed JSA summaries and section this will provide population-level intelligence which, used alongside service-level data provided elsewhere, will enable intelligence-led commissioning and service delivery.

5. Sign off

Rachel Spencer-Henshall, Director of Public Health

6. Next Steps

- Implementation of communications plan to promote new KJSA website and Kirklees.
- Updating of KJSA sections throughout 2016 including summaries for District Committees and CCGs.
- Develop and improve collaborative approach to identifying and capturing assets as part of KJSA development.

7. Recommendations

That the Board:

- Endorse and support the development of a KJSA that informs local commissioning and is rooted in the changing intelligence about local needs and assets and the evidence about what drives health and wellbeing.
- Approve the attached KJSA Overview 2016.

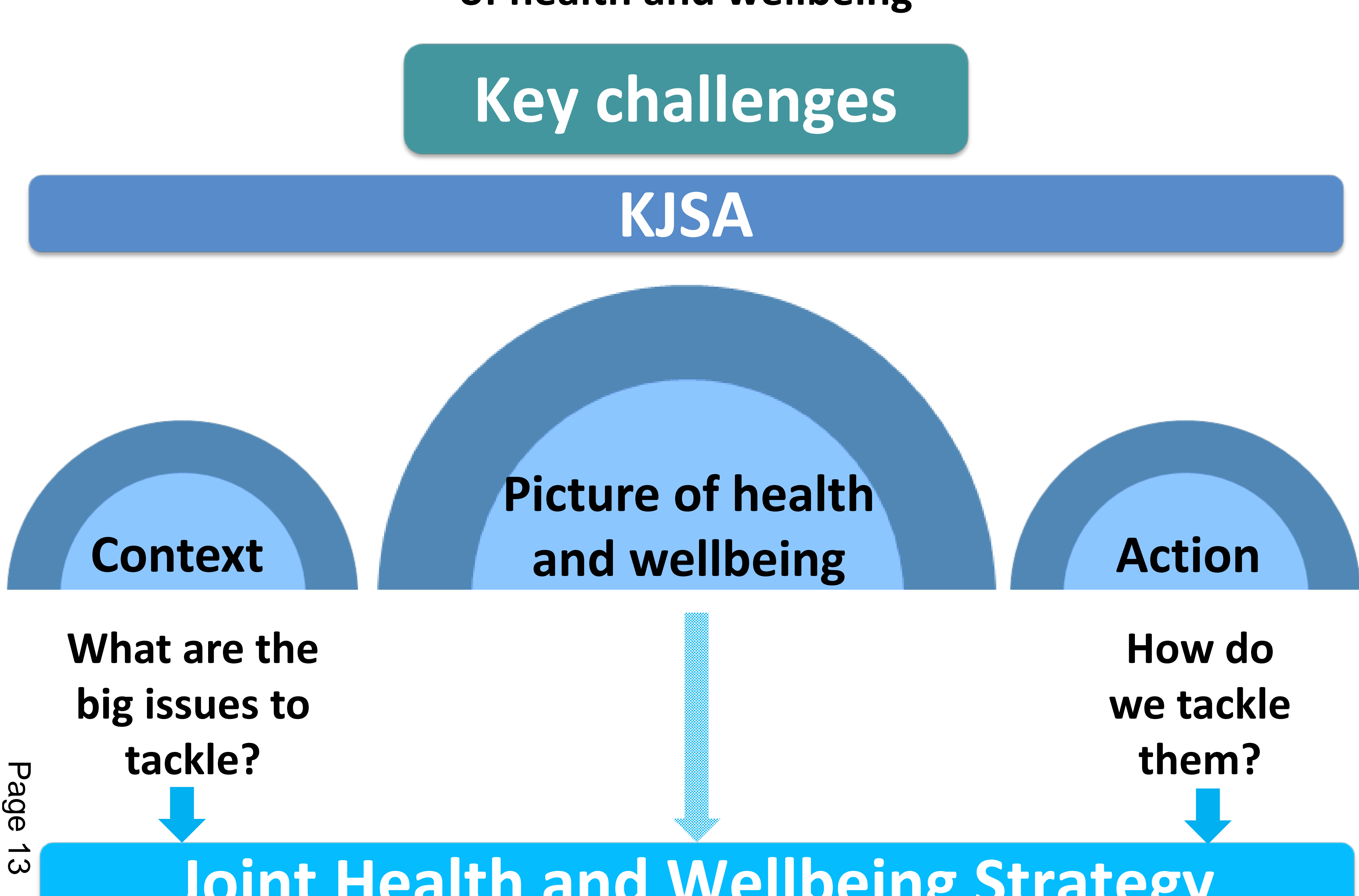
8. Contact Officer

Helen Bewsher, Senior Manager Public Health Intelligence. Helen.bewsher@kirklees.gov.uk

Tony Cooke, Head of Health Improvement. Tony.cooke@kirklees.gov.uk

Introduction to the 'Kirklees Overview' for Health and Wellbeing Board

- The Kirklees Overview 2016 provides an outline of the changing local population and summarises the key population health and wellbeing issues and challenges for the district.
- It provides the context for the more detailed sections of the Kirklees Joint Strategic Assessment (KJSA) being updated in the new web-based format in 2016. Together these should inform and drive the JHWS priorities and actions.
- The overview will be updated annually and the other KJSA sections will be updated approximately 2 yearly to reflect our current cycle of population health and wellbeing surveys.
- The format of the overview illustrates our new approach to communicating intelligence about population health, wellbeing and inequalities making better use of infographics and simple messages.
- The Health and Wellbeing Board is asked to approve this overview and endorse and support the development of a KJSA that informs local commissioning and is rooted in the changing intelligence about local needs and assets and the evidence of what drives health and wellbeing.


The Kirklees Joint Strategic Assessment (KJSA) provides our local picture of health and wellbeing
Key challenges
KJSA
Context
Picture of health and wellbeing
Action
What are the big issues to tackle?
How do we tackle them?
Joint Health and Wellbeing Strategy

Moving to an asset approach

Moving from JSNA to JSA

The Joint Health and Wellbeing Board is committed to the Kirklees Joint Strategic Assessment (KJSA) as an iterative, ongoing process which focuses equally on needs and assets and outlines the medium and longer term challenges for the district.

What is an asset?

Assets are those things that help people and, communities to maintain and sustain their health and well-being. These include things like skills, capacity, knowledge, networks and connections, the effectiveness of groups and organisations and local physical and economic resources, such as green spaces and local businesses.

An asset approach starts by reflecting on what is already present:

What makes us strong/ healthy/ able to cope in times of stress?
What makes this a good place to be? What does the community do to improve health?

How Kirklees can embed an asset approach:

- Understand what is already working and generate more of it
- Actively build capacity and confidence among communities and staff
- Involve the 'whole system' from the beginning
- Design in what is needed to achieve the desired future
- Design out the structures, processes and systems that are stopping this future being achieved

Key challenges

- The need to prevent and intervene early
- Narrowing the inequality gap
- Enabling people to start, live and age well
- Achieving healthy communities, houses and work
- Improving resilience and enabling healthy behaviours (e.g. diet and physical activity)

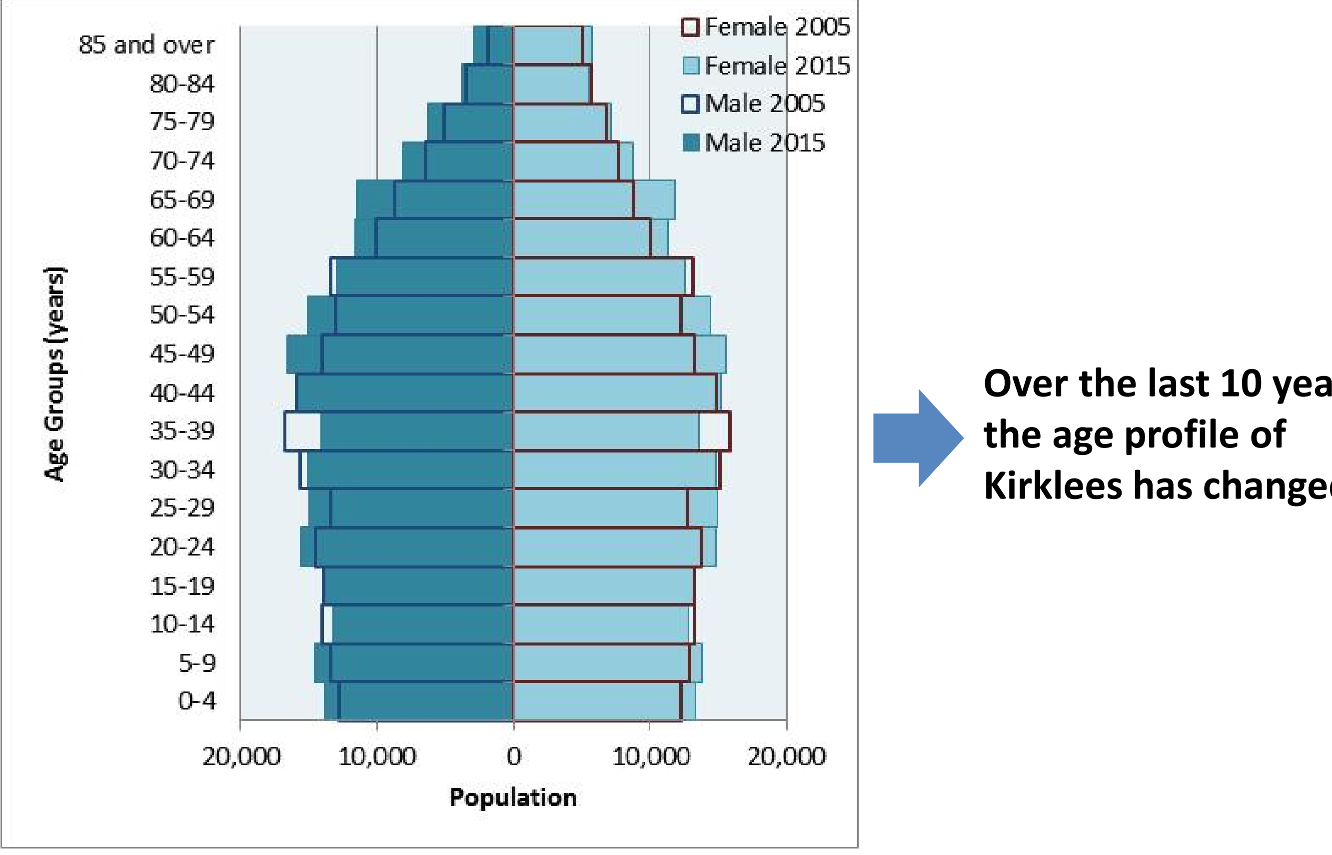
Age structure

Challenges	Strengths
	Increasing life expectancy
	Increasing healthy life expectancy
Dependency ratio	
Ageing with multiple long-term conditions	

People and places

Challenges	Strengths
	Population diversity
Inequalities	

Above average birth rates and an increase in the older population will have implications for the local economy and the health and social care system



Over the last 10 years the age profile of Kirklees has changed

Age	Difference	
	From 2002 to 2015	From 2015 to 2030
85+	+1,495	+6,886
65-84	+11,253	+19,673
45-64	+14,975	-249
25-44	-1,027	-2,425
18-24	+4,027	+707
Under 18	+3,529	+8,858

Increases in older population and under 18s predicted to continue

No overall increase predicted for ages 18-64

Source:
Actual: GP registered populations (WYCSA)
Projected: ONS projections (2012)

In Kirklees the dependency ratio is predicted to rise from 53% in 2015 to 65% by 2030

The **dependency ratio** is the proportion of people who are too young or too old to work. It is calculated by dividing the number of people aged below 15 and above 64 by the number of people aged 15 to 64.

Actual and projected population

Working/non-working age population

400k
300k
200k
100k
0k

2010 2015 2020 2025 2030

Under 15 and 65+ 15-64

Dependency ratio

Dependency ratio (%)

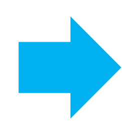
80
60
40
20
0

2010 2015 2020 2025 2030

For every 1,000 people

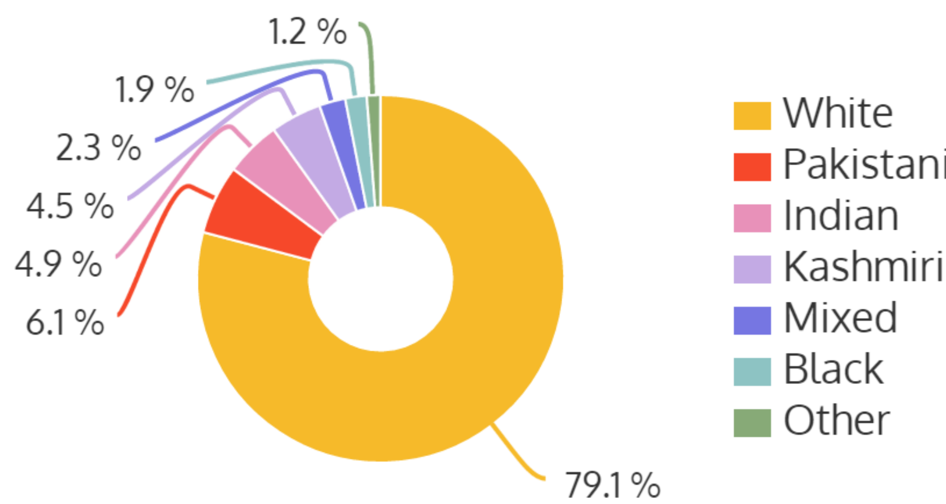
2015		2030
186 (Under 15s) + 163 (65 and over)	< Non-working population >	188 (Under 15s) + 207 (65 and over)
	Supported by	
652 (Age 15-64)	< Working population >	605 (Age 15-64)

So what?



A rising dependency ratio is a concern when it is difficult for pension and social security systems to provide for a significantly older, non-working population. But if more people are working past retirement age it may become less important.

Kirklees has a diverse mix of ethnic, faith and language communities



Ethnicity in Kirklees

The ethnic profile of Kirklees is changing - ethnic minority groups tend to be younger and have more children

White British

77% Total population | **62%** School children

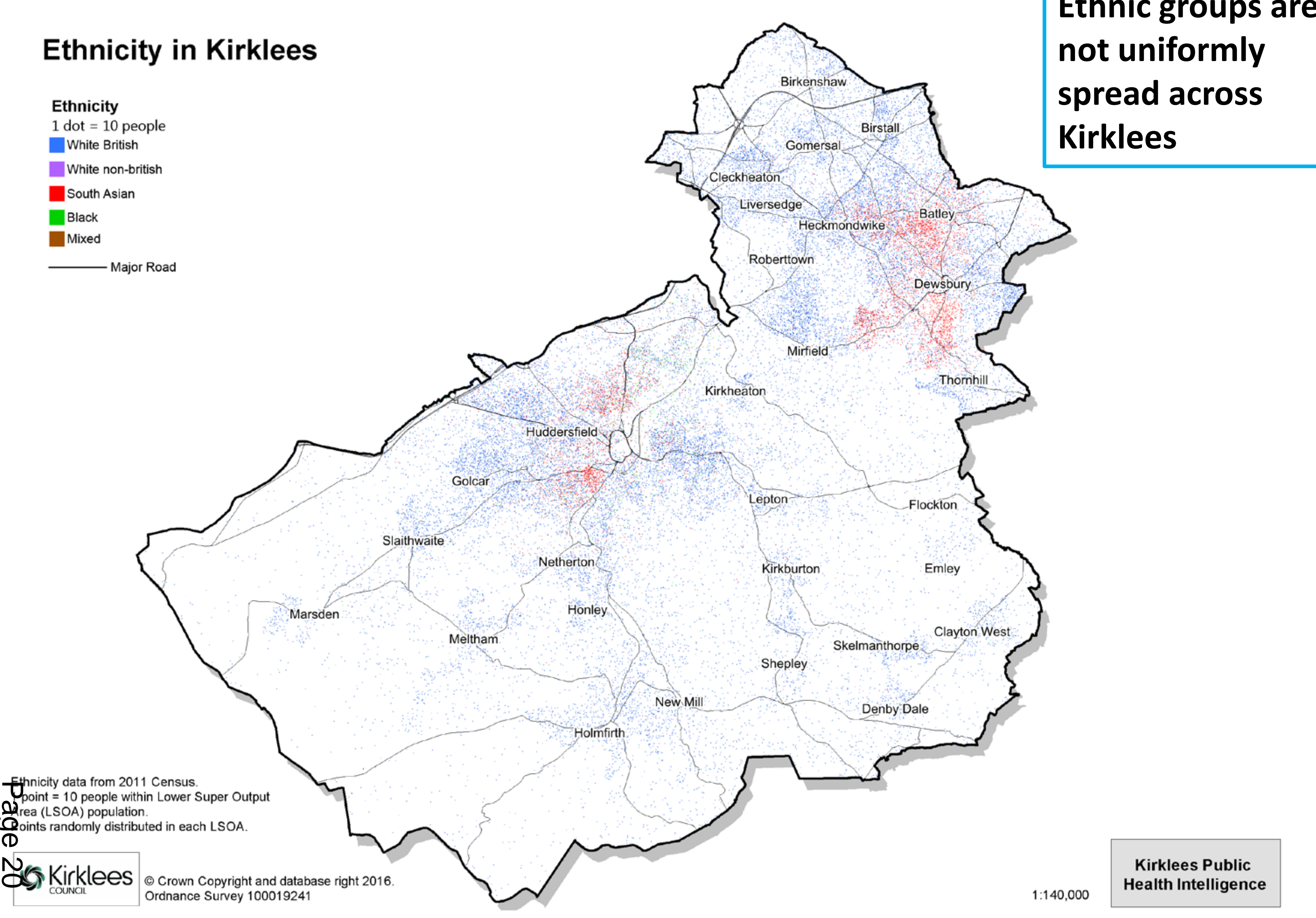
Pakistani

1 in 10 People | **1 in 5** Mothers of new babies

English is not the first language for **1 in 4** primary school pupils

Data sources

Population: Census 2011 (ONS); Schools: School census Jan 2015 (DfE); Mothers: Calderdale & Huddersfield Foundation Trust, Mid-Yorkshire Health Trust 2014/15


Ethnic groups are not uniformly spread across Kirklees
Ethnicity in Kirklees
Ethnicity
1 dot = 10 people
White British
White non-british
South Asian
Black
Mixed
Major Road
Birkenshaw
Birstall
Gomersal
Cleckheaton
Liversedge
Heckmondwike
Batley
Roberttown
Dewsbury
Mirfield
Thornhill
Kirkheaton
Huddersfield
Golcar
Lepton
Flockton
Slaithwaite
Netherton
Kirkburton
Emley
Marsden
Honley
Meltham
Clayton West
Skelmanthorpe
Shepley
New Mill
Denby Dale
Holmfirth
Ethnicity data from 2011 Census.
1 point = 10 people within Lower Super Output Area (LSOA) population.
Points randomly distributed in each LSOA.
Kirklees COUNCIL
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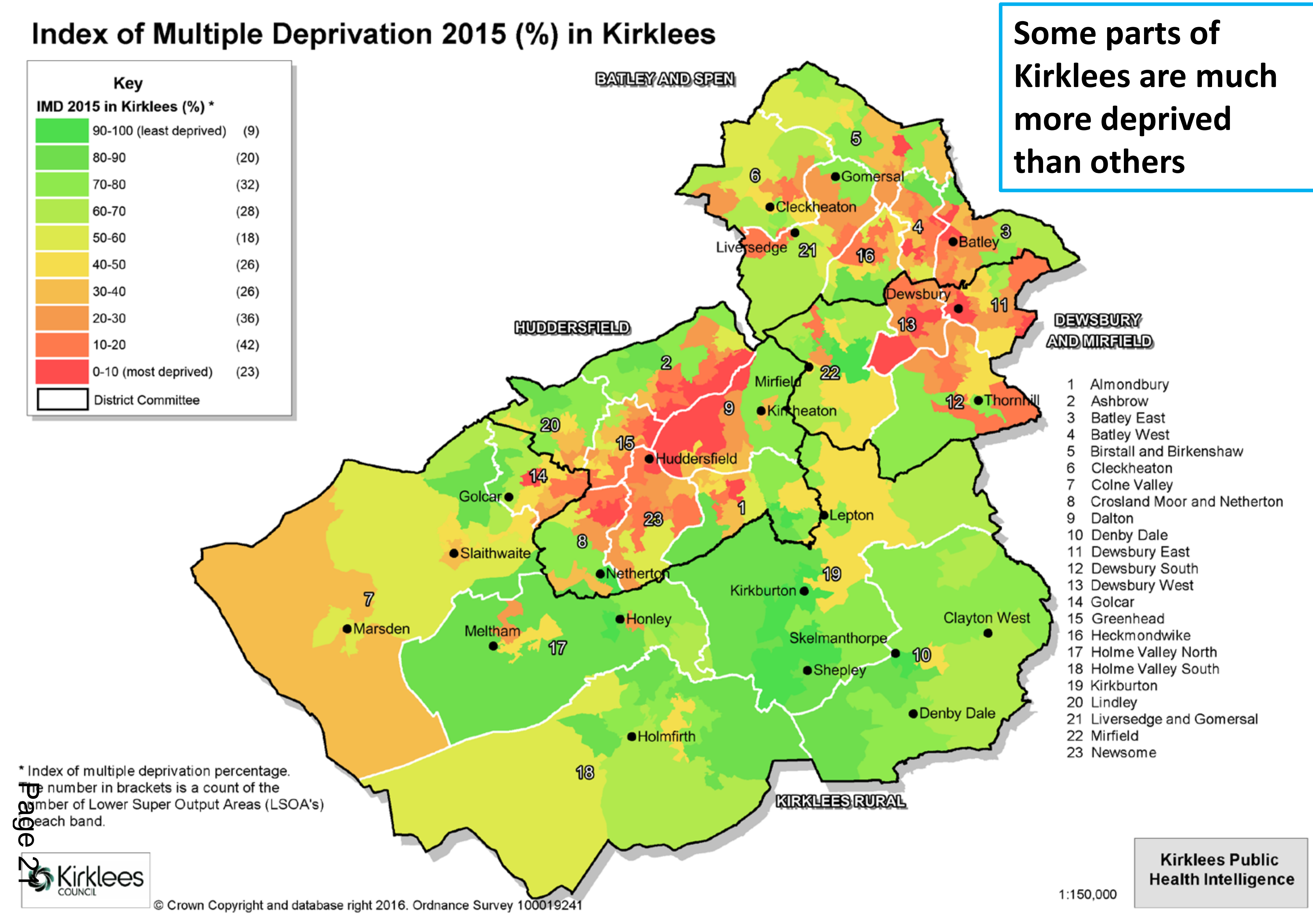
Kirklees Public Health Intelligence



Index of Multiple Deprivation 2015 (%) in Kirklees
Some parts of Kirklees are much more deprived than others
Key
IMD 2015 in Kirklees (%) *
90-100 (least deprived) (9)
80-90 (20)
70-80 (32)
60-70 (28)
50-60 (18)
40-50 (26)
30-40 (26)
20-30 (36)
10-20 (42)
0-10 (most deprived) (23)
District Committee
BATLEY AND SPEN
HUDDERSFIELD
DEWSBURY AND MIRFIELD
KIRKLEES RURAL
Gomersal
Cleckheaton
Liversedge
Batley
Dewsbury
Mirfield
Kirkheaton
Thornhill
Huddersfield
Golcar
Lepton
Slaithwaite
Netherton
Kirkburton
Marsden
Meltham
Honley
Skelmanthorpe
Shepley
Clayton West
Denby Dale
Holmfirth
1 Almondbury
2 Ashbrow
3 Batley East
4 Batley West
5 Birstall and Birkenshaw
6 Cleckheaton
7 Colne Valley
8 Crosland Moor and Netherton
9 Dalton
10 Denby Dale
11 Dewsbury East
12 Dewsbury South
13 Dewsbury West
14 Golcar
15 Greenhead
16 Heckmondwike
17 Holme Valley North
18 Holme Valley South
19 Kirkburton
20 Lindley
21 Liversedge and Gomersal
22 Mirfield
23 Newsome
* Index of multiple deprivation percentage.
The number in brackets is a count of the number of Lower Super Output Areas (LSOA's) in each band.
Kirklees COUNCIL
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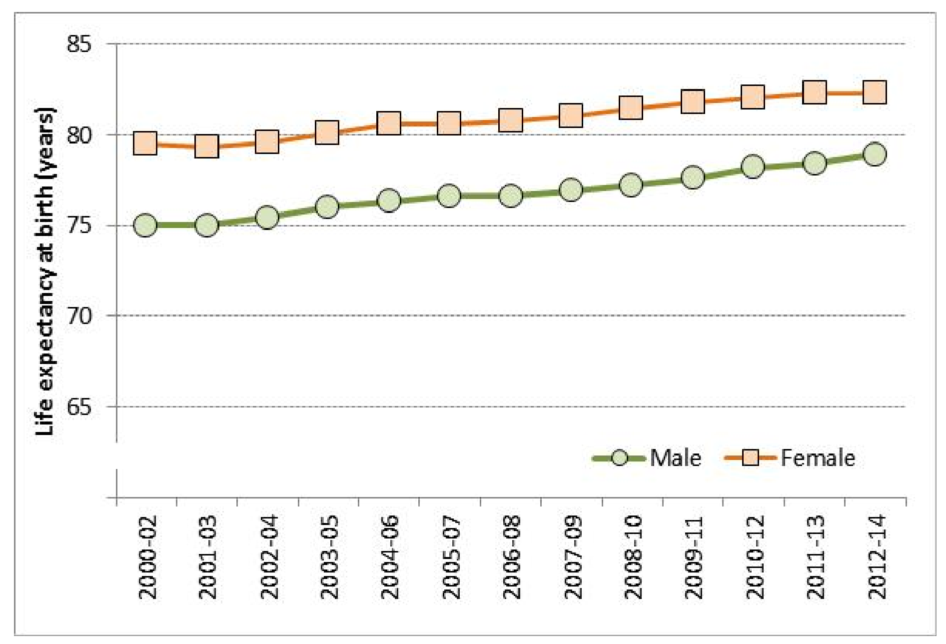
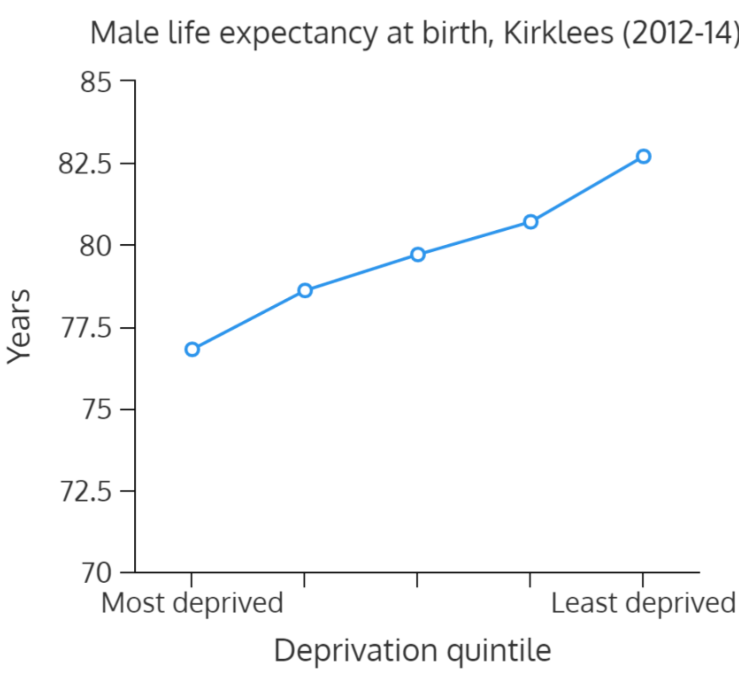
1:150,000
Kirklees Public Health Intelligence

Poor social and economic circumstances affect health throughout life. Life expectancy is shorter and most diseases are more common further down the social ladder. This **social gradient** in health runs right across society.

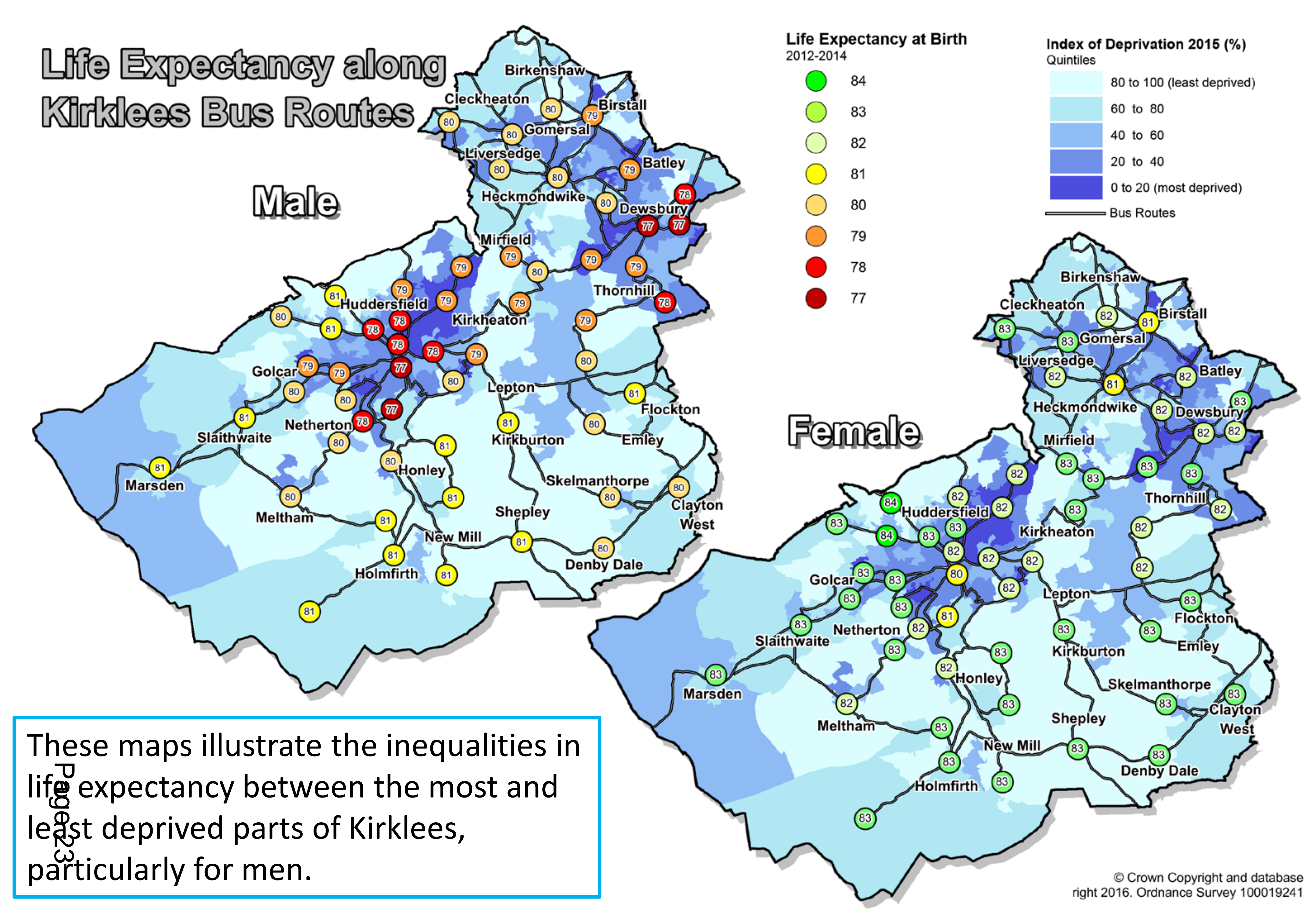


Life expectancy continues to increase. In 2012-14 **life expectancy at birth** in Kirklees was 79.3 years for males and 82.4 years for females.



But there is a clear **social gradient** for life expectancy.

Inequality in life expectancy is a key population health outcome indicator. It is a measure of the social gradient in life expectancy and represents the range in years of life expectancy across the social gradient from most to least deprived. In Kirklees in 2015 this difference was **9 years for males** and **6.3 years for females.**



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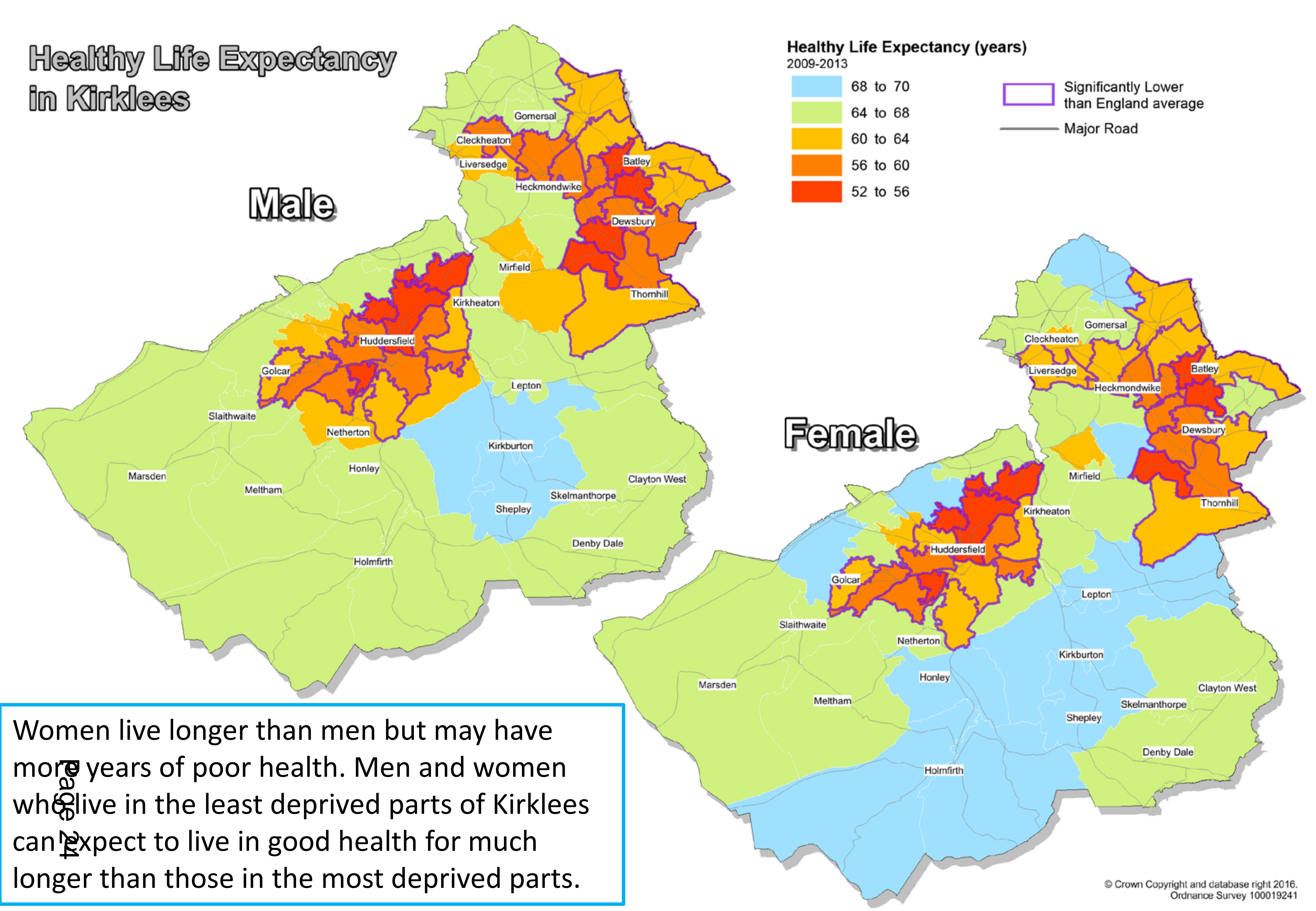

Healthy Life Expectancy in Kirklees
Male
Female
Healthy Life Expectancy (years)
2009-2013
68 to 70
64 to 68
60 to 64
56 to 60
52 to 56
Significantly Lower than England average
Major Road
Gomersal
Cleckheaton
Liversedge
Heckmondwike
Batley
Dewsbury
Mirfield
Thornhill
Kirkheaton
Huddersfield
Golcar
Lepton
Slaithwaite
Netherton
Kirkburton
Honley
Marsden
Meltham
Clayton West
Skelmanthorpe
Shepley
Denby Dale
Holmfirth
Women live longer than men but may have more years of poor health. Men and women who live in the least deprived parts of Kirklees can expect to live in good health for much longer than those in the most deprived parts.
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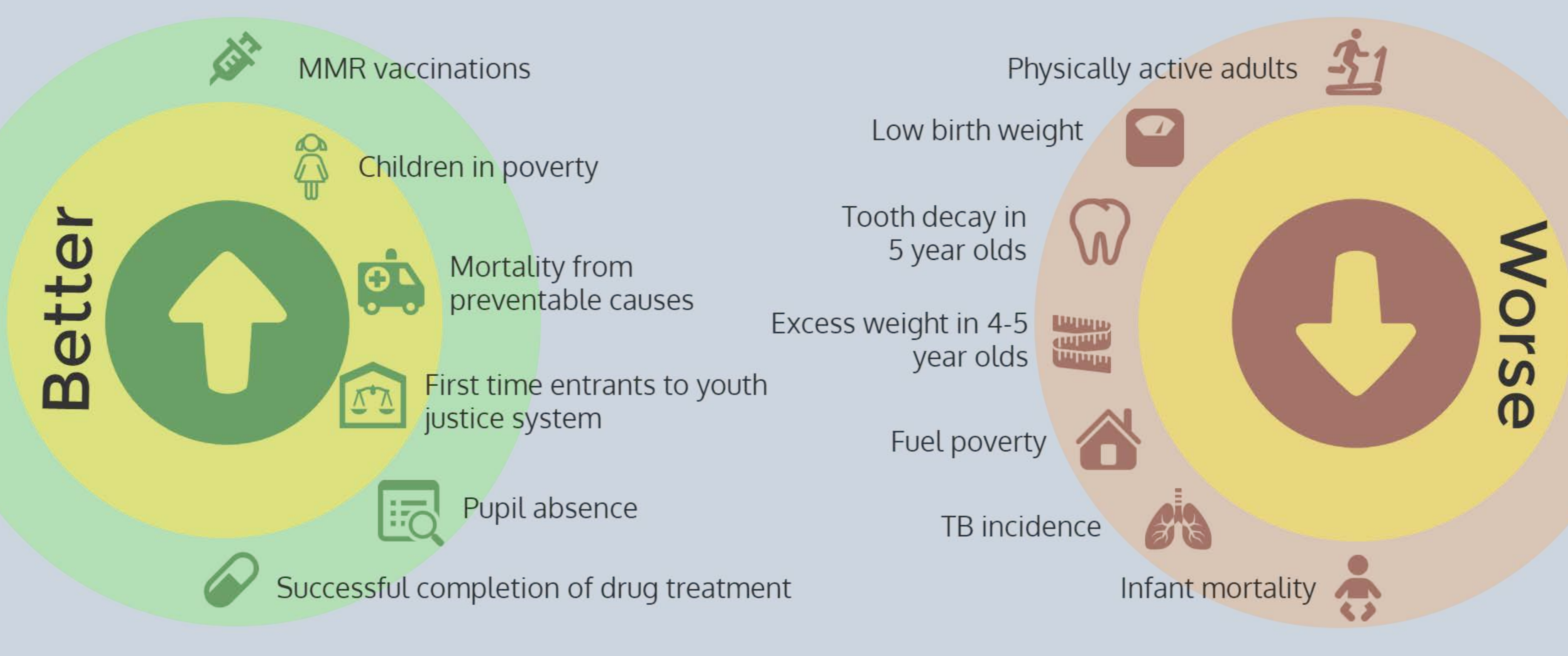
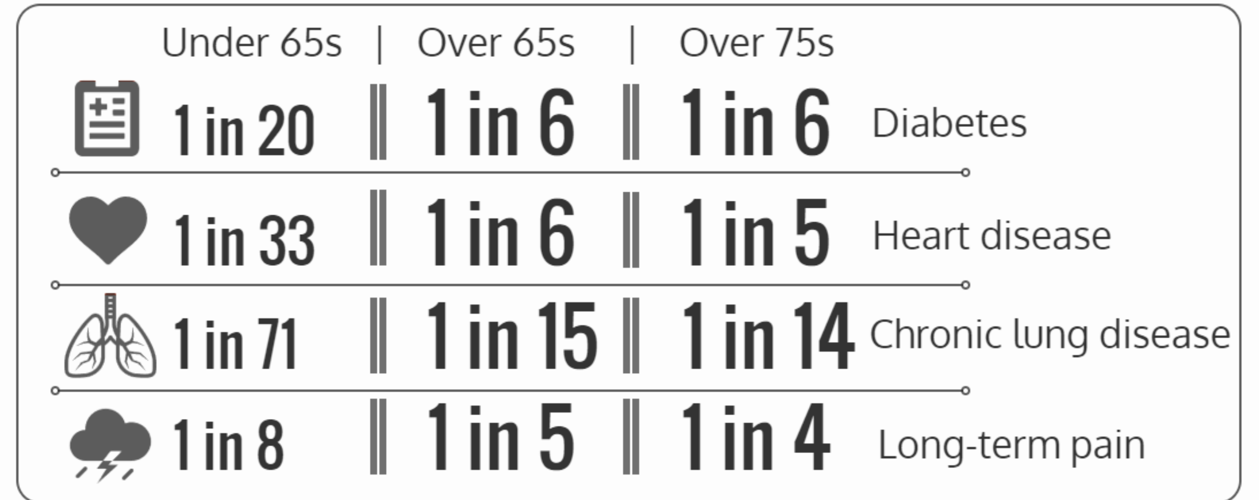
How does Kirklees compare with the rest of the region on key indicators of health and wellbeing?



Long-term conditions

The prevalence of most long-term conditions (LTCs) increases with age

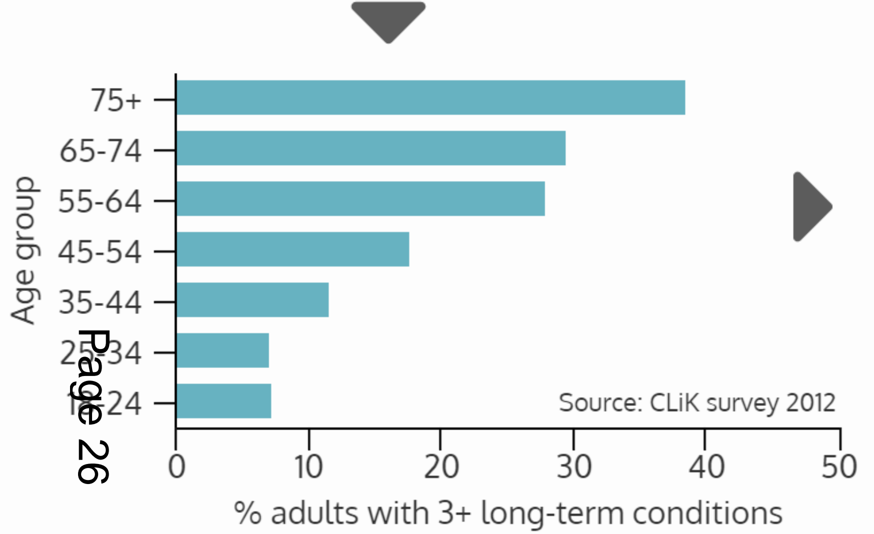


	Under 65s	Over 65s	Over 75s	
	1 in 20	1 in 6	1 in 6	Diabetes
	1 in 33	1 in 6	1 in 5	Heart disease
	1 in 71	1 in 15	1 in 14	Chronic lung disease
	1 in 8	1 in 5	1 in 4	Long-term pain

There are clear inequalities

In over 65s, the rate of diabetes in South Asian people is **double** that of white people

Co-morbidity (having multiple conditions) is most common in older age groups



Mental health problems are most common in younger adults

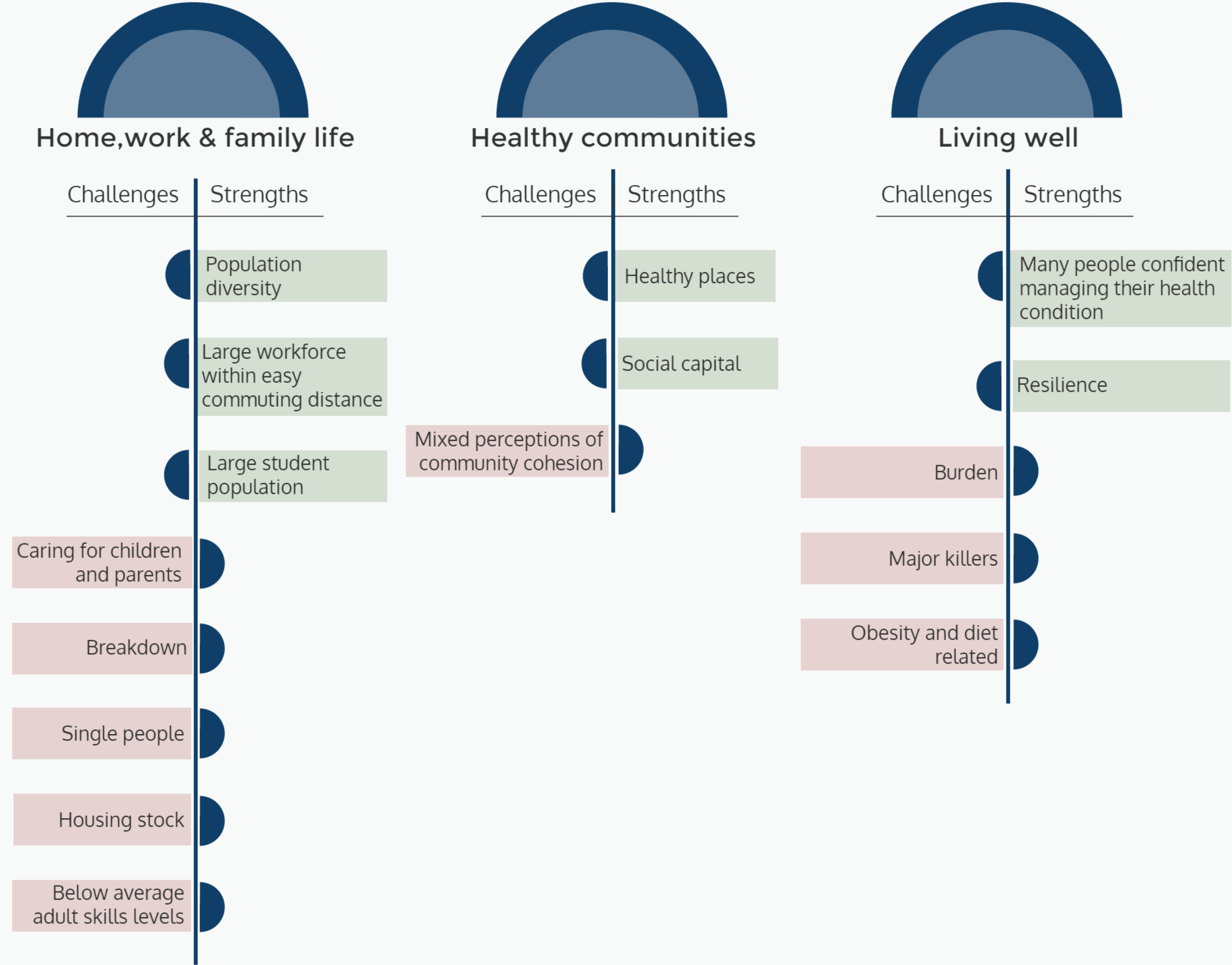
Depression/anxiety	
Under 65s	Over 65s
1 in 4	1 in 8

24,358

Estimated number of people aged 65+ in Kirklees living with 3 or more long-term conditions

3 out of 4

people with a long-term condition feel confident managing their own health


Home,work & family life
Challenges
Strengths
Population diversity
Large workforce within easy commuting distance
Large student population
Caring for children and parents
Breakdown
Single people
Housing stock
Below average adult skills levels
Healthy communities
Challenges
Strengths
Healthy places
Social capital
Mixed perceptions of community cohesion
Living well
Challenges
Strengths
Many people confident managing their health condition
Resilience
Burden
Major killers
Obesity and diet related

Home, work & family life

Households

60% don't have children living in them

24% are occupied by one person

16% are occupied by pensioners

Family life

2 in 5

children experience family breakdown

(at least half of which occurs by age 3)

Housing

Within Yorkshire & Humber, Kirklees is one of the more affordable places to live, but it has relatively low income levels

Demand for suitable & affordable accommodation outstrips supply

Residents living in private rented homes

2001	2015
12%	17%

Work

Employed: **200,700** 16-64 yr olds

Unemployed:
- **7,463** Not claiming/not eligible for JSA
- **4,437** Claiming JSA

Long-term sick: **15,600**

People who feel lonely/isolated all/most of the time:

Employed	Unemployed	Not working (long-term sick/disabled)
1 in 33	1 in 6	1 in 4

Over half of all poverty is now found in working households

Over next 18 years...

1,630 new homes need to be provided each year

1,049 of these need to be affordable housing

This map illustrates which parts of Kirklees have the largest proportion of households in fuel poverty. Deprived areas and rural areas are affected.

What drives fuel poverty?

- The energy efficiency of the property
- The cost of energy
- Household income

Low Income High Cost (LIHC) Fuel Poverty Indicator in Kirklees by LSOA - 2011 (Based upon DECC data, published August 2013)

LIHC Percent households in Fuel Poverty

Range	Count
14 to 100	(47)
12 to 14	(37)
10 to 12	(79)
8 to 10	(71)
0 to 8	(26)

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Healthy communities

Most (94%) adults do not feel lonely or isolated

However... **1 in 4** { - Adults with bad/very bad health
- Adults not working due to ill health/disability

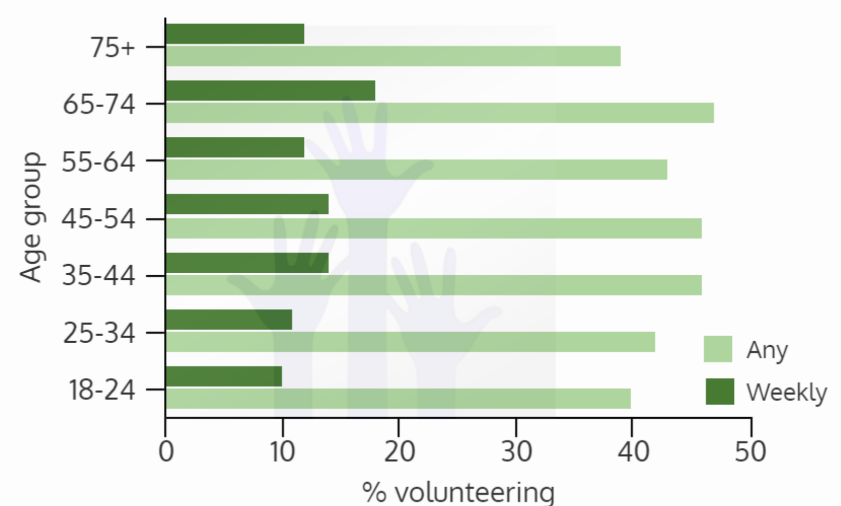
...feel lonely/isolated most/all of the time

60% of people aged over 75 live alone

---

1 in 5 Adults volunteer at least monthly

Volunteering levels are highest at retirement age and between ages 35-54



People living in least deprived areas are

twice as likely

to trust other local people

as those in most deprived areas

Perceptions of trust between local people:

Most deprived quintile	Least deprived quintile
33%	59%

Source: YPYS survey 2011

Having children aged 5-17 in the household increases levels of volunteering

Healthy places

1 in 21 of annual deaths in people over the age of 30 are caused by air pollution

1 in 7 people use outdoor space for exercise/health reasons

1 in 3 people commute less than 5 km to work by car

Half of people perceive there are problems with traffic issues (speeding, parking, etc)

Mode of travel to work

1 in 17 on foot

1 in 100 by bicycle

1 in 3 young people travel actively (bike or walk) to school

Disease and wellbeing

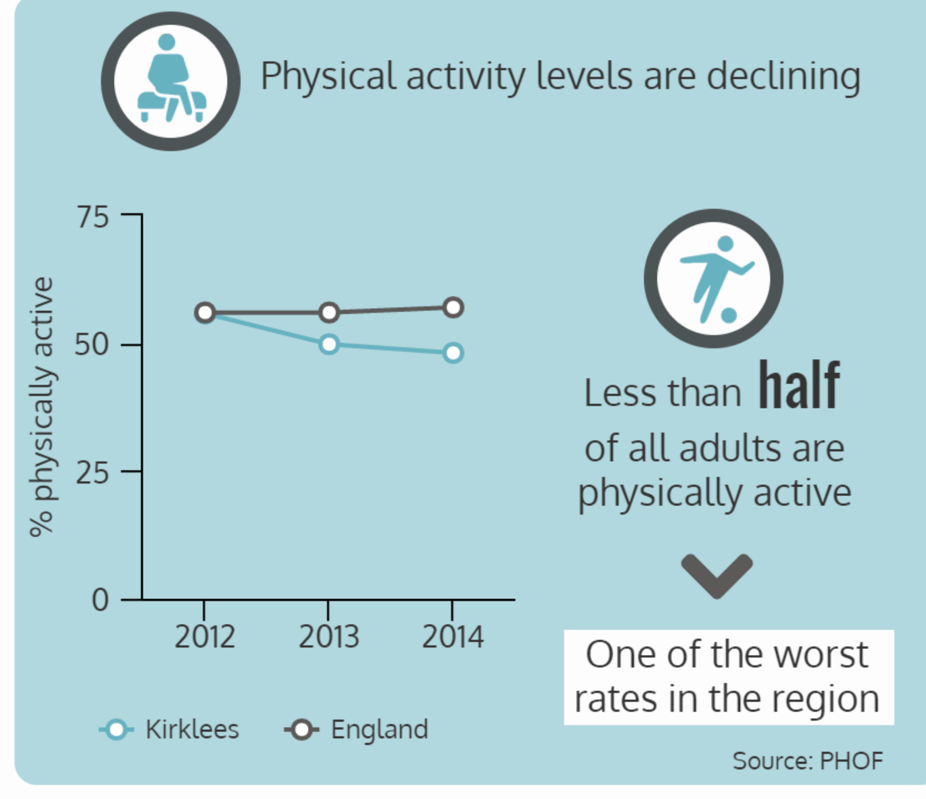
Diet contributes more than any other risk factor to the total **burden of disease** in the UK

Kirklees adults are

heavier and less active

in 2015 than in 2013

2 in 3 adults are now overweight/obese



Source: PHOF

Emotional wellbeing

1 in 4 adults under 65 have experienced anxiety, depression or other mental health problem

1 in 4 adults report taking time off work for stress, anxiety or depression

Kirklees has the lowest rate of suicide in the region (7.9 per 100,000)

but **every suicide is a tragedy** and affects many people

Importance of starting well

Challenges	Successes
	School readiness
	Children's wellbeing & resilience
Infant mortality	
Low birth weight	
Childhood obesity	

Clustered behaviours/vulnerable groups

Challenges	Successes
	Highly motivated individuals in all parts of Kirklees
	Reduced drug use amongst children & adults
Multiple risky behaviours	
Vulnerable groups with complex needs	

Starting well

Infant mortality

Infant mortality rates in Kirklees are amongst the highest in the region and highest in the most deprived areas

However rates have almost halved in the last decade:

2003-05	2012-14
8.0	4.6

deaths per 1000 live births

Low birth weight

Over the last 10 years, Kirklees has one of the highest rates of low birth weight term babies in the region

Rates in 2014/15 are twice as high for South Asian mothers as for White British mothers:

South Asian	White British
6.2%	2.9%

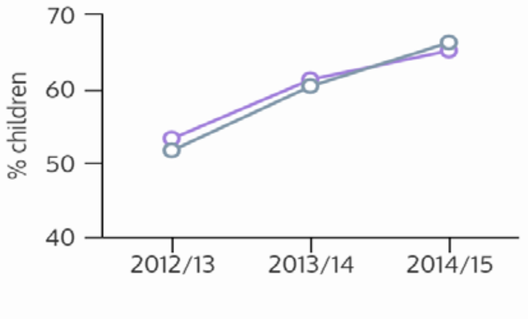
Healthy weight

Reception age children: **3 in 4**

Year 6 children: **2 in 3**

Obesity levels amongst pupils living in the most deprived decile are **double** those in the least deprived decile (Reception and Year 6)

% children achieving good level of development at end of reception is improving, in line with England value

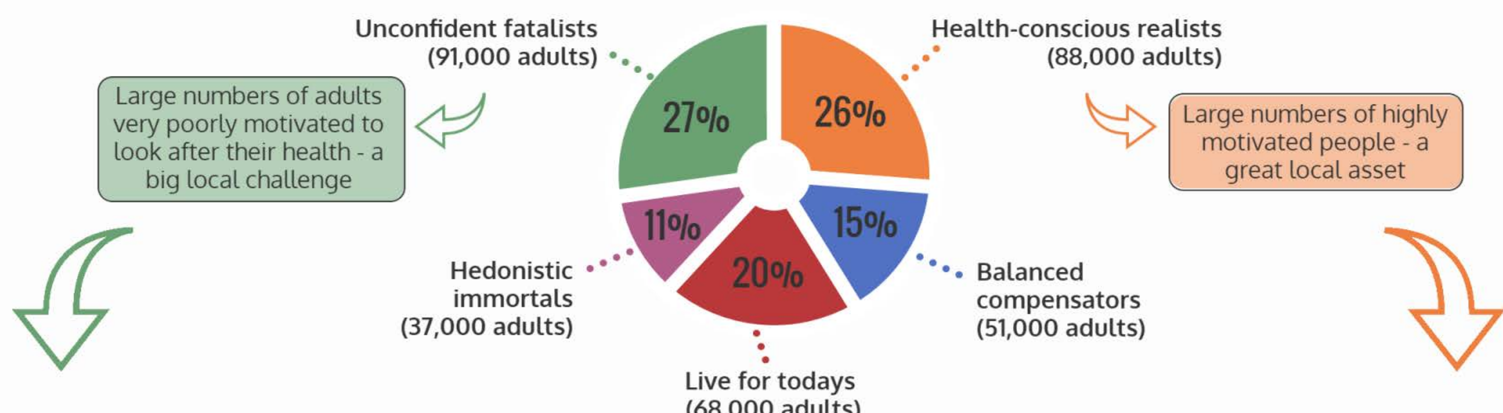


School readiness

Pupil absence:
Levels are better than England, and are improving

NEET:
Proportion of NEET is steadily falling and is similar to the England average (4.8% in Jan 2016)

Clustered behaviours



Unconfident fatalists (91,000 adults):

Profile
Oldest age profile, tend to live in most deprived areas, largest proportion of workless (under 65s), similar ethnicity profile to Kirklees overall

Behaviours, motivations & risk factors
Negative perceptions of a healthy lifestyle, often fatalistic about their own health, multiple negative health behaviours (apart from alcohol), poor social connectedness

Preferred approach, format, communication and engagement
UFs are likely to need more support to take small steps in a staged and coordinated approach to tackle multiple issues. They respond better to NHS branding, peer testimonials ('people like us can change') and face to face engagement methods.

Health-conscious realists (88,000 adults):

Profile
Middle aged profile, tend to live in less deprived areas, smaller than average proportion of workless (under 65s)

Behaviours, motivations & risk factors
Highly motivated, in control of their lives and their health, positive health behaviours, better than average health & wellbeing, better than average social connectedness

Preferred approach, format, communication and engagement
HCRs are already engaged with health so are most likely to prefer an approach that is primary care based, non-prescriptive, non-medical and facilitative. They respond better to local rather than NHS/ Government branding and to messages focusing on control and individual choice.

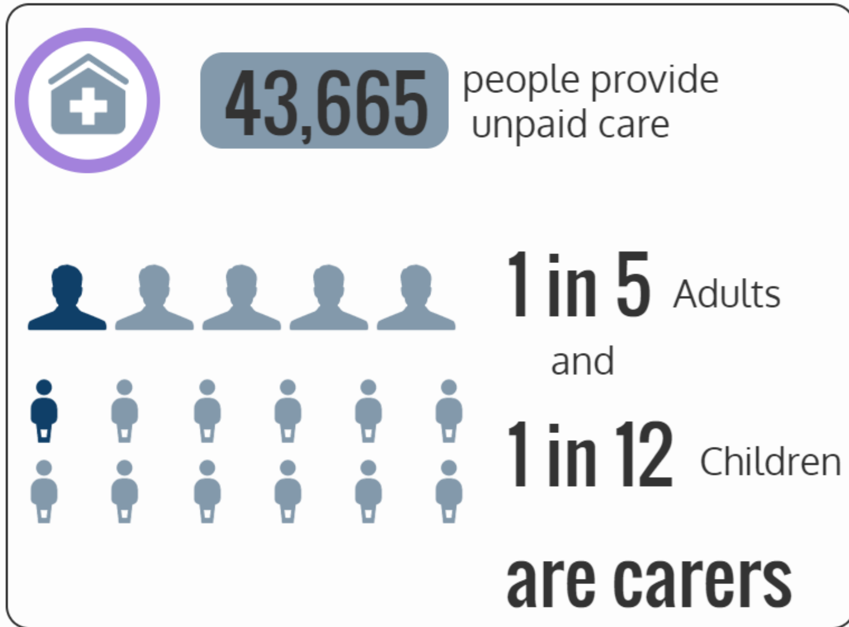
What is Healthy Foundations?

Healthy Foundations is a segmentation model originally developed for the Department of Health to provide insights for social marketing to improve the effectiveness of healthy policy, campaigns and interventions. It is built on the three core dimensions of motivations, environment and life stage. It identifies five distinct motivation segments which differentiate people based on health attitudes and beliefs. The segments are 'Unconfident Fatalists (UF)', 'Health Conscious Realists (HCR)', Balanced Compensators', 'Hedonistic Immortals' and 'Live for Todays'. These are labels used to describe the segments only **not** labels to be assigned to individuals.

So what?

Different intervention, engagement and communication formats and approaches are needed for people in each segment. This will be more effective than a 'one size fits all' approach. There are people who are highly motivated to look after their health living in **all** parts of Kirklees. In the more deprived areas, highly motivated individuals (Health Conscious Realists and Balanced Compensators) can take on the role of 'health champions'.

Supporting vulnerable groups



43,665 people provide unpaid care

1 in 5 Adults

and

1 in 12 Children

are carers

54,500 working age people are disabled

including 7,500-8,300 adults with a learning disability

Kirklees has **610** looked-after children

Out of 65,788 pupils....

4,222 receive SEN support

1,819 with SEN statement

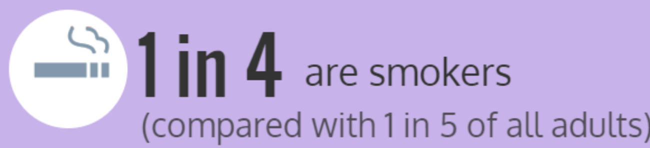
1,880 people supervised by Probation Service

Around 91,000 adults are in the segment most poorly motivated to look after their health

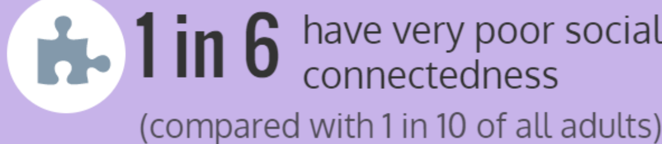
Of these 91,000...

1 in 4 is obese
(compared with 1 in 5 of all adults)

1 in 5 have four or more long-term conditions
(compared with 1 in 11 of all adults)



1 in 4 are smokers
(compared with 1 in 5 of all adults)



1 in 6 have very poor social connectedness
(compared with 1 in 10 of all adults)

Key challenges

- The need to prevent and intervene early
- Narrowing the inequality gap
- Enabling people to start, live and age well
- Achieving healthy communities, houses and work
- Improving resilience and enabling healthy behaviours (e.g. diet and physical activity)

How do we tackle them?

- Redouble efforts to shift activity from reacting to preventing and intervening early
- Create environments that enable healthy behaviours
- Ensure interventions are designed and targeted to reduce inequalities
- Promote independence and resilience to start well and age well
- Ensure access to healthy housing, decent work and strong community
- Ensure changes are driven by community assets and strengths to achieve positive and sustainable outcomes

Joint Health and Wellbeing Strategy

KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**Sustainability & Transformation Plan Development**
TITLE OF PAPER:	**30th June 2016**

1. Purpose of paper

To provide the Board with an update on progress with developing the Sustainability and Transformation Plan (STP), particularly the Healthy Futures component and the feedback from the Scenario Planning event held on 26th April 2016.

2. Background

The Board has received regular updates on the development of the STP since January 2016. NHS England recently announced that there should be a 'checkpoint submission' by 30th June 2016, and that the final submission date will be in the Autumn.

Scenario planning event

One strand of the development of the STP was the recent Scenario Planning event hosted by the Board. The event brought together 40+ senior leaders from across the Council, NHS and other partners for a full day workshop on 26th April 2016. The event was facilitated by Sue Goss from OPM.

The event used a series of potential future scenarios to develop plans to sustain the principles in the JHWS and the emerging Sustainability and Transformation Plan. The future scenarios were very challenging, but realistic – and designed to enable us to foresee future challenges and opportunities, and 'future-proof' current plans – thinking more radically about ways to achieve desired outcomes in very different futures.

The write up of the event is attached (Appendix 1). What emerged from the work done by participants was a set of key actions and potential principles to guide us in the future.

Kirklees STP Development

The Kirklees STP Working Group which has representation from CCGs, Council, all 3 Trusts and Locala is continuing to work on developing a draft STP.

The focus is not just on addressing the mandatory requirements set out by NHS England but also on reinforcing the importance of developing a Kirklees system wide view of both the challenges we face and the proposed solutions that draws on existing and emerging organisational and partnership plans, issues emerging from the updated JSA, the scenario planning event and the Healthy Futures work.

There will be a presentation to the Board on the current draft.

Healthy Futures

The West Yorkshire STP is being developed with the active involvement of all key partners across West Yorkshire and Harrogate. The work is being led by Rob Webster, Chief Executive of South West Yorkshire Partnership NHS Foundation Trust.

The development of the WYSTP is informed by a set of principles and a draft set of aims has been developed (see Appendix 2). The proposed structure, governance and leadership arrangements are under development and will be shared with the Board as soon as they are available.

3. Proposal and next steps

- Any feedback from NHS England on the 30th June checkpoint submission will be shared with the Board.
- Further drafts of the Kirklees STP and the West Yorkshire STP will be circulated to all members of the Board for comment as they become available.
- Both CCGs have a detailed plan for engaging with their respective stakeholder groups, including providers, and Governing Bodies.
- Other members of the Working group are also ensuring that drafts are taken through their own internal processes as necessary.

4. Financial Implications

Not applicable

5. Sign off

Carol McKenna, Greater Huddersfield CCG Chief Officer and STP Senior Responsible Officer

Richard Parry, Director for Commissioning, Public Health and Adult Social Care

7. Recommendations

That the Board

- Note the progress and next steps in developing the Healthy Futures and Kirklees STPs.
- Note the set of key actions and potential principles that emerged from the Scenario Planning event and agree to these being reflected in the Kirklees STP where appropriate.
- Receive the final draft of the Kirklees STP for approval at the Board meeting prior to the final submission date set by NHS England.
- Delegate authority, if required, to sign off the Kirklees STP submission to Carol McKenna, STP Senior Responsible Officer, and Richard Parry, Director for Commissioning, Public Health and Adult Social Care in consultation with the Cabinet Portfolio Holder - Prevention, Early Intervention and Vulnerable Adults.

8. Contact Officers

Phil Longworth, Health Policy Officer, Kirklees Council

Rachel Millson, Business Planning Manager, North Kirklees CCG

Natalie Ackroyd Business Performance Reporting and Planning Manager, Greater Huddersfield CCG

Kirklees Health and Wellbeing Board
Scenarios Event
26th April 2016
Report-back

The Kirklees Health and Wellbeing Board brought together 40+ senior leaders from across the Council, NHS and other partners for a full day workshop on 26th April 2016. The event was facilitated by Sue Goss from OPM. The programme and outline of the purpose of the event are in Appendix 1. Participants worked on the five scenarios for 2020 attached in Appendix 2. The scenarios had been developed from a range of national publications in consultation with a range of people involved in the Health and Wellbeing Board. Each scenario set out a different possible policy, structural and organisational context – but assumed the same health and wellbeing issues for Kirklees based on the analysis in the JSNA – and the same desired outcomes as set out in the Joint Health and Wellbeing Strategy.

The discussions prompted by the scenarios were wide-ranging and rich – but we set out below some of the key actions that emerged based on the issues arising from each scenario.

1. Key actions:

A Vision for Kirklees: Given that the desired outcomes are set out in the JHWS – the next step is to create a coherent, shared vision about how to get there – involving everyone – including private and voluntary sectors – an approach that everyone can buy into and contribute to. The Health and Wellbeing Board could move from 'a committee' to a 'leadership group' – engaging all sectors in the actions needed to make change happen.

Think beyond boundaries – both geographical and functional: We need to connect to neighbouring authorities and learn from other places – and integrate not simply within sectors but across. The greatest creativity comes when we connect different approaches.

Re-think the commissioner-provider split: While competition may bring dynamism and creativity – it adds costs for both providers and commissioners. We need to find a way to keep creativity and efficiency within a more collaborative co-production model – removing waste at all levels and allowing scope for emergent solutions and innovation.

Be smarter about joining things up: We need to be courageous about really joining up and pooling budgets when this adds real value – but only join things up when it makes sense – not when it slows us down.

Link to the economy: We need to make health and wellbeing a key aspect of housing, planning, leisure transport and economic policy – and vice-versa.

Stand collectively as a Kirklees economy – with an agreed shared direction, standing shoulder to shoulder against interference and unhelpful regulation.

Recognise there are many different sorts of private sector – learn about them and understand their motivation – think about how they can contribute – as employers, potential partners in creating employment, providers, retailers, sponsors, through corporate responsibility etc.

Recognise the contribution of the voluntary and community sector: not just as a provider of services – but contributing ideas, resources, funding sources, volunteers, energy, new models and approaches – engage with them fully – not just 'ticking the box'.

Rethink the workforce: We need to create a flexible and responsive workforce for the next decade – attracting good staff into health and social care – creating career paths between sectors and organisations. We need to rekindle the debate between generic, multi-skilled and specialist staff – who need to be able to respond to the 'whole person'. We need to work together to find ways to attract good staff into Kirklees.

Digital roadmap - Need to take advantage of what technology offers – understand what is possible and work collaboratively to take up new opportunities.

Draw on a wider range of assets and resources: in our organisations, the community and the private sector – e.g. use schools as a key player in creating health and wellbeing.

Create the right environment for self-help: Create the spaces within which people can learn to improve their own health and wellbeing and we need to create the right environment that helps people to change behaviour.

2. Principles to guide us into the future:

- Be more collaborative in our behaviours – less defensive – support each other - recognise that a 'win' for another organisation is also a win for us and the outcomes we want.
- Build trust - bring the right people together for the right work – trusting each other (I don't have to go to everything) and inviting each other in to share thinking.
- Learn to understand each other's problems and motivations – understand the motivation of private sector and voluntary sector players.
- Inject pace – be faster and more purposeful – recognise that if we move faster we will make mistakes and that's OK – we will learn faster that way.
- Be braver about taking risks across the whole system – trust the common sense of local people (kids climbing trees, or patients taking paracetamol).
- Be more exploratory and pro-active – e.g. engage with young people to understand their views and attitudes – they are the future!
- Change language and assumptions – 'service user' and 'patient' assumes we do things to people – instead talk about people and understand what they bring and contribute.
- Take leadership action– we have the ability to change things within our gift – for example by how we develop the STP.
- Hold each other to account for making change happen

Appendix 2

The West Yorkshire STP

Principles for Developing and Delivering the WYSTP

The WYSTP and Healthy Futures programme have agreed that the following principles will underpin our approach to working together:

- We will be **ambitious** for the people we serve in closing the 3 gaps
- The WYSTP **belongs to commissioners, providers, local government and NHS,** including the health, care and financial challenges we face
- We will apply **subsidiarity principles** in all that we do – WY has a supporting function performing only those tasks which cannot be effectively delivered at a local level
- We recognise the vast majority of transformation to improve outcomes is being delivered at a local level and therefore the **local STPs have primacy**
- We will **agree a shared analysis** of problems and issues as the basis of taking action
- We will **do the work once** – duplication of systems, processes and work should be avoided as wasteful and potential source of conflict
- We will **always make decisions together where we can** – working together, meeting together and making joint recommendations to the appropriate decision-making forums in WYSTP and our own membership organisations
- We will use the 'WY lens' to prioritise all areas where we will work collaboratively: [see Appendix 2]

  - ✓ What can we only achieve by working at a WY level in order to deliver the best outcomes?
  - ✓ Where does working at a WY level give us more leverage to achieve the best outcomes?
  - ✓ Where can we share best practice across WY in order to achieve the best outcomes?

These principles will continue to apply to all of our work and underpin this proposal.

Aims of the WYSTP (What do we want to deliver?)

- To **develop a collaborative leadership across West Yorkshire** to support evidence-based decision- making
- To **understand the gaps in outcomes** - health and well-being outcomes, care and quality outcomes and funding outcomes, that exist in West Yorkshire across health and social care. This will be presented as an agreed cumulative position across commissioners, providers and local authorities in the WYSTP
- To scope and develop **plans for addressing these gaps** through the delivery of programmes of transformation work which deliver the greatest and fastest possible improvement in outcomes for patients
- To scope and develop a **WY sustainability plan** which will ensure that all the required health and care services are sustainable within the West Yorkshire funding allocations [by ? which year]
- To **commission and deliver** health and care services (whether collectively, as local STPs or individual CCGs with local authorities) which offer the **best possible value for WY pound spent** based on the improvements to outcomes, reduction in variation and the standardisation of commissioning approach across West Yorkshire
- To develop an **integrated approach to delivering** the health and care which people need which delivers the best possible outcomes for patients, the best value for pound spent and supports future sustainability in WY
- To enable transformation through the utilisation of **new models of care**, contracting, funding and innovation
- To **access and allocate the various sources of transformational funding** to support the delivery of these transformational programmes, understanding the return on investment, the benefit to patients in terms of improved outcomes and the benefit to services in terms of addressing sustainability pressures
- To take a **WY-wide perspective when considering the total funding** available for the next five years across WY and collectively consider how to address the current and future sustainability challenges, funding gaps and opportunities for commissioning with this funding

KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**30 June 2016**
TITLE OF PAPER:	**An integrated approach to improving outcomes for children and young people, their families and their communities in Kirklees: the contribution of the Healthy Child Programme 0-19**

1. Purpose of paper

To update the Board on progress with developing the Healthy Child Programme (HCP) 0-19 as a key part of the activity aiming to transform services for children and young people.

To ask the Board to endorse the

- vision for an integrated approach to the Healthy Child Programme 0-19
- the outcomes for the programme and a set of principles to underpin the approach
- use of the HCP 0-19 as a catalyst for changing the way we do things.

2. Background

In January 2014 the Board discussed the range of activity aiming to transform services for children and young people, specifically the CAMHS Transformation Plan, the Stronger Families programme, the Disabled Children's Strategy and the development of the Healthy Child Programme.

The HCP is an evidence-based programme of best practice which provides a *framework* to support collaborative work and more integrated delivery. The Council has statutory responsibility for commissioning public health services for children and young people aged 5-19. The responsibility for commissioning for 0-5 year olds transferred from NHS England to local authorities on 1 October 2015. This represents an excellent opportunity to take a more integrated whole family approach.

The proposals set out in this paper were discussed and endorsed by the Children's Trust Partnership in March 2016

3. Proposal

The attached 'key messages' document highlights the proposed vision and outcomes:

Kirklees is a great place to grow up where every child and young person…

- *is safe and loved, healthy and happy and free from harm, and*
- *has the chance to make the most of their talents, skills and qualities to fulfil their potential.*

It is an opportunity to bring together organisations, people and services to develop a shared approach so that…

- *every child has the best start in life*
- *all children, young people and adults maximise their capabilities and have control over their lives.*

The proposed principles that will underpin the approach are

- Prioritising a whole family approach;
- Involving and engaging children, young people, families and communities;
- Working together seamlessly to improve life chances;
- A partnership approach;
- Leading and providing strategic direction;
- Seeking creative ways to improve outcomes;
- Adapting to changes and reductions in resources;
- Using evidence to inform interventions and support;
- Integration, integration, integration.

The Kirklees Healthy Child Programme 0-19 represents the best opportunity yet to transform services for children and young people from conception to age 19. Work is progressing well to engage with partners across systems and sectors to inform a model for a re-designed Kirklees HCP. There is strong commitment to ensuring this work makes a full contribution to Kirklees Transformation Plan for children and young people's mental health and wellbeing. The approach being taken is focussed on using the Kirklees HCP as a *catalyst* for the transformation & integration of systems, interventions and services. This will require systems leadership across a range of partners and systems. The attached diagram shows some of the 'starting well' systems and services involved in achieving the vision and outcomes.

Governance

A Programme Management approach has been established to oversee this process, including:

- Interdisciplinary Project Steering Group
- Programme Leaders Group (KH, TB, KP)
- Programme Governance Group (DPH Chair, AD members from Council and CCG, Clinicians)
- Reports to Council's EIP Programme Board and PH Quality Board

4. Financial Implications

The services that are currently delivering elements of the HCP and CAMHS include:
Health visiting and FNP (0-5 year old public health resource).
School nursing (5-19 year old public health resource)
Child and adolescent mental health service (CAMHS) tiers 2 and 3
Pilot SPA CAMHS Transformation Plan
Nurturing Parent/Preparing for Parenthood
Children's weight management/NCMP
Healthy Start vitamin scheme.
HomeStart
Autistic Spectrum Conditions
Accident Prevention
Food for Life (CYP)

The current contract values/service budgets for these services have determined the financial envelope. Commissioners will be seeking savings over the contract term but with demonstrable improved outcomes for children, young people and families.

5. Sign off

Richard Parry, Director for Commissioning, Public Health and Adult Social Care

6. Next Steps

- Engagement and co-design with children and families completed by June, 2016.
- Stakeholder engagement completed by June, 2016.
- Service specification/tender documents complete by August, 2016.
- Tender process August, 2016 – December, 2016.
- Award contract December, 2016.
- Service implementation – April, 2017.

7. Recommendations

That the Board:

- endorse the vision for an integrated approach to the Healthy Child Programme 0-19, the outcomes and principles to underpin the approach to delivery of the programme
- support the use of the Healthy Child Programme 0-19 as a catalyst for changing the way we do things.

8. Contact Officers

Keith Henshall - Head of Health Improvement (Starting Well) Keith.Henshall@kirklees.gov.uk
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Kirklees healthy child programme (HCP) 0-19 years – what's it all about?
Key messages

Thursday 30/06/2016

1. What is the healthy child programme?
The context for the work is set by Professor Sir Michael Marmot's review, *Fair Society, Healthy Lives* (2010). The review had two aims - *to improve health and wellbeing for all* and *to reduce health inequalities*. To achieve these, the review recommended six objectives, the first and second of which are all about improving outcomes for children and young people:

- Give every child the best start in life, and
- Enable all children, young people and adults to maximise their capabilities and have control over their lives.

2. How does this fit with the Local Transformation Plan
In March 2015, the report of the Children and Young People's Mental Health Taskforce, *'Future in Mind'* set out a clear direction to improve children's mental health and wellbeing.

A key recommendation was the development of 'Local Transformation Plans', to promote partnership working and drive improvements in children and young people's mental health and wellbeing over the next 5 years. Extra funding was made available to local areas on the development of Local Transformation Plans to drive sustainable service transformation to improve children and young people's mental and emotional health and wellbeing.

Kirklees was successful in attracting the extra funding.

3. Our vision
Kirklees is a great place to grow up where every child and young person…
- is safe and loved, healthy and happy and free from harm, and
- has the chance to make the most of their talents, skills and qualities to fulfil their potential.

4. What do we want to achieve?
We want to bring together organisations, people and services to develop a shared approach so that…
- every child has the best start in life
- all children, young people and adults maximise their capabilities and have control over their lives.

5. Commissioning services
The Health and Social Care Act 2012 sets out a local authority's statutory responsibility for delivering and commissioning public health services for children and young people aged 5-19 years.

Responsibility for children's public health commissioning for 0-5 year olds, specifically health visiting services and Family Nurse Partnership, transferred from NHS England to local authorities on 1 October 2015.

The move to commissioning of children's public health services by local authorities is an opportunity to take a fresh look at a whole family approach. This means new opportunities for bringing together a robust approach for improving outcomes for children, young people and their families.

6. **Kirklees Integrated Healthy Child Programme**
The intention is to use the HCP approach for the integration of a range of systems, interventions and services in order to improve outcomes for children, young people, their families and communities, with a focus on mental and emotional health and wellbeing.

The plan covers the whole spectrum of services for children and young people's mental health and wellbeing from health improvement and prevention work, to support and interventions for children and young people who have existing or emerging mental health problems, as well as transitions between services.

7. The commissioning plan
To design and deliver more integrated child and family health services in Kirklees using the framework of the HCP to improve the outcomes for children, young people and their families. The services that are currently delivering elements of the HCP and CAMHS include:

- Health visiting and family nurse partnership (0-5 year old public health resource).
- School nursing (5-19 year old public health resource)
- Children and adolescent mental health service (CAMHS) tiers 2 and 3
- Learning from the pilot Single Point of Access in the CAMHS Transformation Plan
- Children's weight management service
- Healthy vitamin scheme.

Commissioners hope that any potential model will be innovative and demonstrate a robust, fully integrated delivery partnership approach. They are intending to encourage collaboration wherever possible.

8. Key design focus
The effectiveness of proposals for delivery of the new HCP model will be assessed according to the degree to which they:

- Integrate resources and Build integrated ways of working
- Focus 'upstream' on improving the agreed outcomes and preventing problems
- Reduce inequalities – proportionate help according to need and available assets
- Improve primary and secondary prevention across life stages
- Build in easy access to advice and help from a range of sources
- Embed 'nurturing parent' and enables parents to develop the 'confidence to care' and children and young people to self-manage (e.g. developing child/parent led care planning)
- Increase independence and decreases service dependency & Re-design support to promote resilience and emotional wellbeing
- Focus on four sources of support: 'Personal Relationships', 'Family (parent carer)', 'Community Capacity', 'Learning Environments'
- Demonstrate a coherent workforce design and development strategy and implementation plan.
- Demonstrate robust information governance and best practice in information sharing, including the potential for shared client record systems
- Support the development of the Learning and Community Hubs
- Promote relationship based approaches
- Ensure a robust support network of partner agencies, including access to advice, consultancy and supervision.

9. Timescales

- Market provider engagement completed by January, 2016.
- Engagement and co-design with children and families completed by June, 2016.
- Stakeholder engagement completed by June, 2016.
- Service specification/tender documents complete by August, 2016.
- Tender process August, 2016 – December, 2016.
- Award contract December, 2016.
- Service implementation – April, 2017.

10 Need more information?

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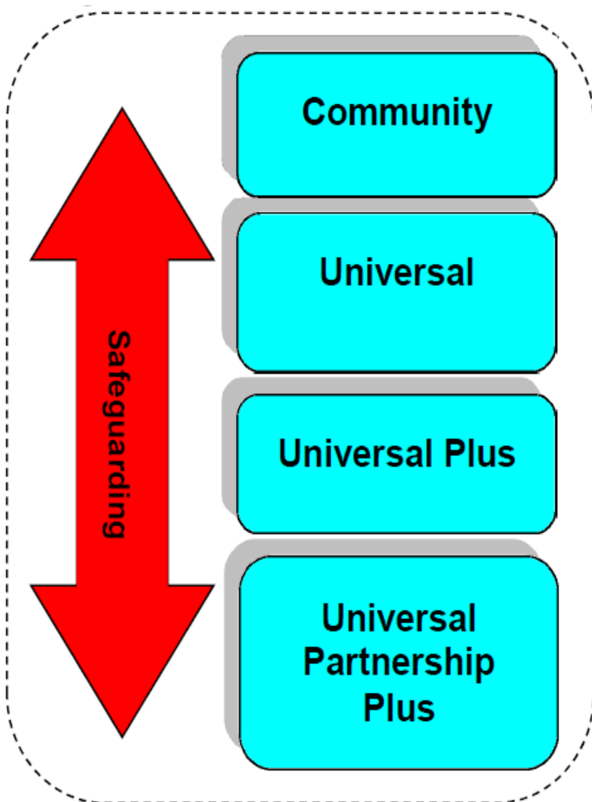
The Current Healthy Child Programme Model



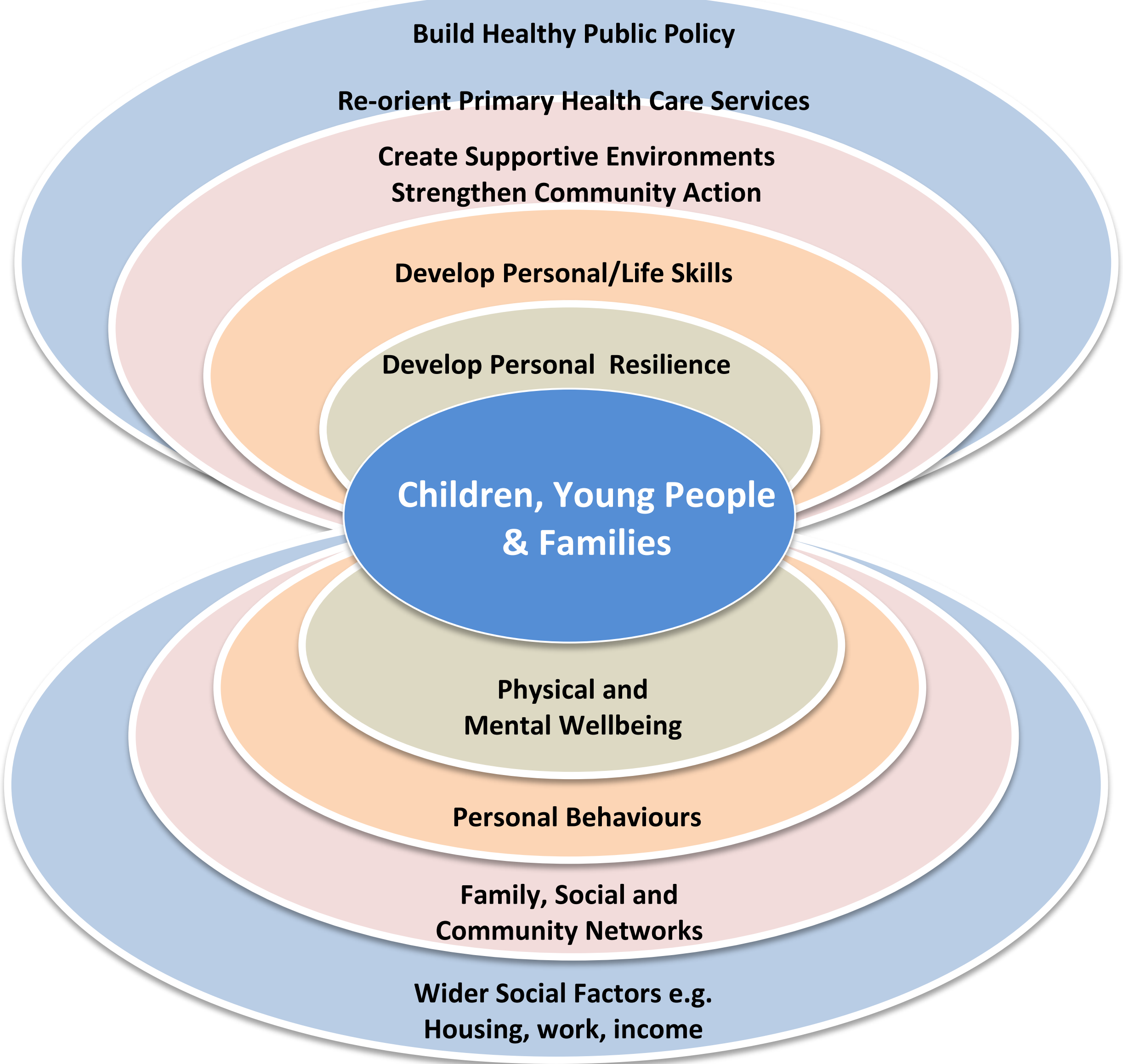
The Community describes a range of activities, services and support in the community for children, young people and their families. The HCP helps in developing and providing these and making sure people know about them.

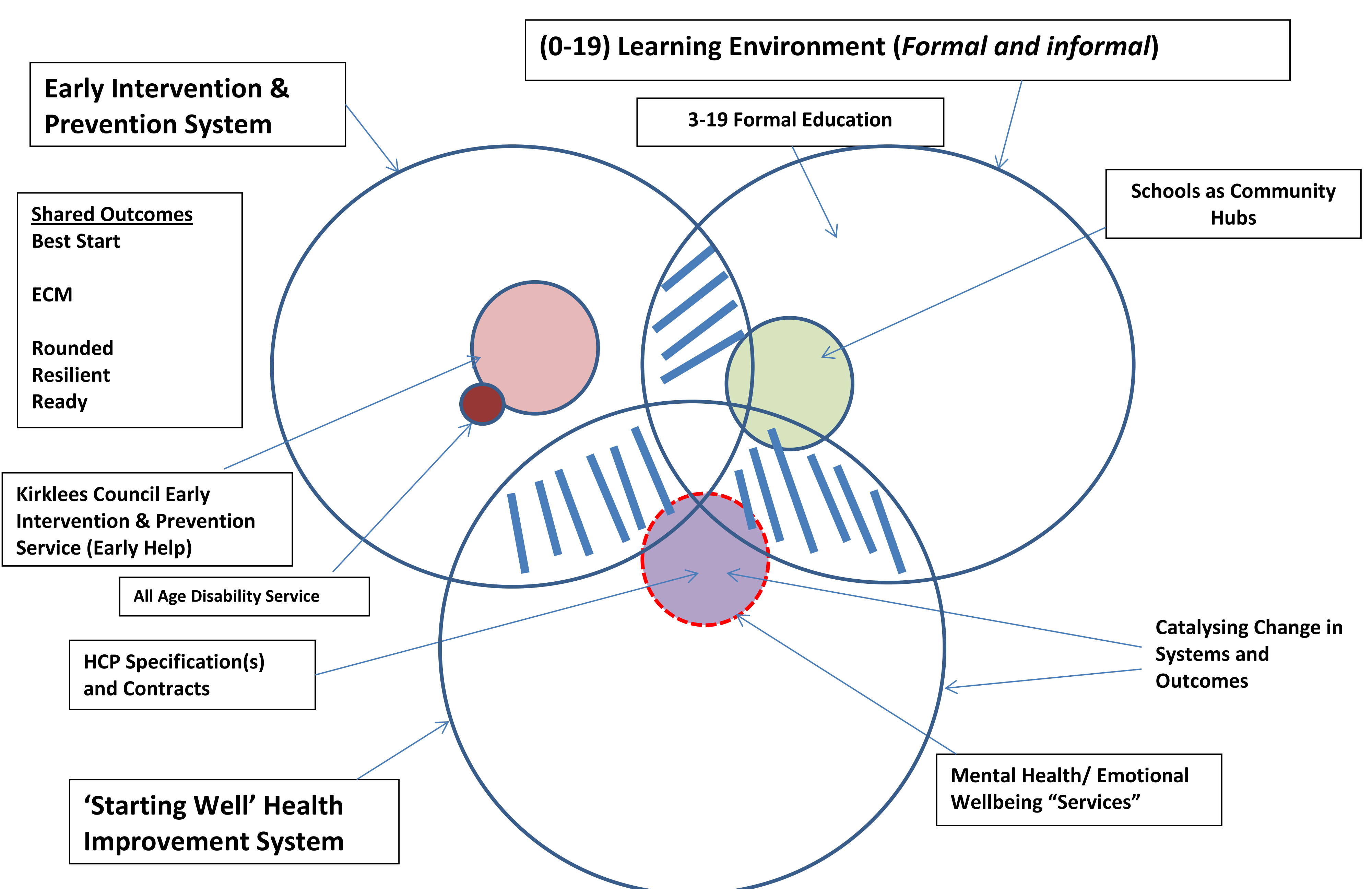
Universal HCP to ensure a healthy start for every child. This may include promoting wellbeing and resilience, for example through listening and supporting, and protecting health e.g. by immunisations and identifying problems early.

Universal Plus provides a swift response when specific expert help is needed which might be identified through an assessment or through providing accessible services that people can go to with concerns. This may include managing long-term health issues and additional health needs, reassurance about a health worry, advice on sexual health, and support for emotional and mental health and wellbeing.

Universal Partnership Plus delivers ongoing support as part of a range of local services working together and with the family to deal with more complex problems over a longer period of time.

The Proposed New Model for Kirklees Integrated Healthy Child Programme




'STARTING WELL' SYSTEMS
(0-19) Learning Environment (*Formal and informal*)
Early Intervention & Prevention System
3-19 Formal Education
Schools as Community Hubs
Shared Outcomes
Best Start
ECM
Rounded
Resilient
Ready
Kirklees Council Early Intervention & Prevention Service (Early Help)
All Age Disability Service
HCP Specification(s) and Contracts
Catalysing Change in Systems and Outcomes
Mental Health/ Emotional Wellbeing "Services"
'Starting Well' Health Improvement System

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FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 30 June 2016

TITLE OF PAPER: A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES: CONTEXT, DESIGN PRINCIPLES AND OPTIONS

1. Purpose of paper

This paper outlines emerging plans to move towards commissioning an integrated wellness model of health improvement focused on integration and system change rather than narrower 'silo-based' based interventions. The paper is coming to the Board to inform, and consult with, Board members.

2. Background

This is a major service redesign based on integration of a number of services and interventions covering health improvement, self-care and long term conditions. Reasons for this approach include:

- Integration will improve outcomes: Potential to deliver both health improvement and prevention and early intervention outcomes at different points in the life-course.
- Integration will promote strategic alignment across the health and social care system as outlined in the Joint Health and Wellbeing Strategy.
- Integration is increasingly evidenced: A common skill-set focusing on behaviour change is applicable across health improvement interventions (with some tailoring to population groups and exceptions for the most vulnerable where elements of specialist provision may still be needed).
- People should tell their story once where possible: Ongoing health inequalities and people presenting with more than one issue necessitate a move towards a "one-stop shop" approach that minimises confusion and supports a system-wide approach.
- Integration will promote collaboration and innovation across providers and be rooted in community engagement and co-production.
- Integration will promote self-care, resilience and community connectedness.
- The current system is not financially sustainable as long term conditions are increasing and creating a larger burden on the health and social care system.

Key Considerations are:

- The money required to establish the service is available from current budgets as existing contracts end.
- The wider 'wellness model' architecture needs to be designed by all partners, including determining the approach to commissioning.
- The model needs to be integrated with, and is integral to, the council Early Intervention and Prevention Programme whilst also having broader aims than preventing people entering the social care system. It also aligns with and informs the NHS Five Year Forward View and Sustainability and Transformation Plans.
- People are living longer but many are living with extended periods of disability.
- Two-thirds of people are overweight and/or obese but we do not have the resources to offer medical treatment so a different and more effective approach is needed.

3. Proposal

It is proposed that a range of services are integrated into a new approach. Some of these are noted in the paper. Decisions have not yet been made about the exact shape of the new model and discussions are needed about how best to implement a radical approach that will improve outcomes, reduce costs across the system and promote collaboration.

4. Financial Implications

Resources will be made available from existing budgets as current contracts end. It is anticipated that an 'integration dividend' will be achieved through economies of scale and merger of existing approaches.

5. Sign off

The paper has been discussed by both Greater Huddersfield and North Kirklees CCG.

6. Next Steps

As outlined in the paper, partnership based Governance structures are being set up, a Project Plan determined, consultation/insight developed and budgets/risks determined.

7. Recommendations

It is recommended that the Board note the paper and agree to support the development of an integrated wellness model for Kirklees.

8. Contact Officer

Tony Cooke, tony.cooke@kirklees.gov.uk

A COMMUNITY WELLNESS MODEL OF HEALTH IMPROVEMENT FOR KIRKLEES

CONTEXT, DESIGN PRINCIPLES AND OPTIONS

1. SUMMARY

This paper outlines initial thinking and emerging plans to move towards commissioning integrated wellness models of health improvement rather than narrower 'silo-based' based interventions. Reasons for this approach include:

- Integration will improve outcomes: Potential to deliver both health improvement and prevention and early intervention outcomes at different points in the life-course.
- Integration will promote strategic alignment across the health and social care system as outlined in the Joint Health and Wellbeing Strategy
- Integration is increasingly evidenced: A common skill-set focusing on behaviour change is applicable across health improvement interventions (with some tailoring to population groups and exceptions for the most vulnerable where elements of specialist provision may still be needed).
- People should tell their story once where possible: Ongoing health inequalities and people presenting with more than one issue necessitate a move towards a "one-stop shop" approach that minimises confusion and supports a system-wide approach.
- Integration will promote collaboration and innovation across providers and be rooted in community engagement and co-production.
- Integration will promote self-care, resilience and community connectedness.

Key considerations:

- The money required to establish the service is available from current budgets.
- The wider 'wellness model' architecture needs to be designed by all partners, including determining the approach to commissioning.
- The model needs to be integrated with, and is integral to, the council Early Intervention and Prevention Programme whilst also having broader aims than preventing people entering the social care system
- The current system is not financially sustainable as long term conditions are increasing and creating a larger burden on the health and social care system.
- People are living longer but many are living with extended periods of disability
- Two-thirds of people are overweight and/or obese but there are insufficient resources to offer medical treatment so a different and more effective approach is needed.
- We must prioritise reducing the impact of key risk factors at an avoidable earlier stage whilst promoting better self-management for people with more serious needs

2. CONTEXT

2.1 Widening the scope of Public Health interventions

A number of existing Public Health "lifestyle" service contracts end between March 2016 and March 2018. This paper sets out the case for recommissioning services as an integrated Wellness Service as part of a wider wellbeing model that is better aligned with New Council and the Target Operating Model, Early Intervention and Prevention and the NHS Five Year Forward View. The Joint Health and Wellbeing Strategy and Transformation and Sustainability Plans outline the importance of system-wide change and this approach offers a genuine opportunity to deliver an improved collaborative offer across Kirklees.

There are many definitions of wellness; broadly they all emphasise a proactive, preventive approach that focus on the whole person and which works to achieve optimum levels of physical, mental, social and emotional health. Good nutrition, healthy weight, exercise, increased resilience, emotional health and wellbeing and avoiding risk factors such as tobacco and alcohol misuse all play a role in wellness, as does a feeling of community connectedness and social capital.

The wellness approach goes beyond looking at single-issue, healthy lifestyle services with a focus on illness, and instead aims to take a whole-person and community approach to improving health. Based on self-care and intervening as early as possible but as late as necessary, it is clear that individuals who manage their own lifestyles are healthier, more productive, have fewer absences from work, and make fewer demands for medical and social services. Early intervention and prevention, keeping people healthy and out of acute and expensive urgent services, has direct financial advantage to the Council and NHS and longer term health and wellbeing advantages for residents.

2.2 From a top-down deficit model to a provider/community-led approach

The previous public health paradigm focused on using a combination of legislation, campaigns and direct intervention to generate top-down change. Successes included reduced smoking and drug use and control of major infectious diseases such as HIV. Whilst the recent Sugar Tax shows that legislation will remain a key lever, the emerging public health paradigm is centred on promoting health and wellbeing across the life-course but rooting this within an approach focused on building social capital and strong, resilient communities. Individual health behaviour is increasingly understood within the context of the social and economic influences on health and the multiple, diverse systems people inhabit (Marmot, 2010). Working across these systems to promote healthy lifestyles and so prevent and delay the onset of non-communicable disease, promote healthy ageing and tackle health inequality is therefore a key function of the New Public Health.

However, increased academic understanding about the importance of system-wide change is within the context of smaller public services, reduced budgets and devolution. This will require providers that are better able to innovate, are flexible enough to work across silos and inclusive enough to put the user/patient before organisational demands. Changing our local culture to one that promotes health improvement also means providers must challenge themselves and the system to generate new ideas about service improvement. Closer to the ground and more agile, providers should be effective collaborators across systems using partnership building and leadership to develop trusting and strong networks. New models also require a workforce that prioritises relationships over technical skills and are able to operate at the edges of their authority.

A distinctive Kirklees approach would also utilise an Assets and Strengths based approach to promote community connectedness and social capital and be rooted in a user-led approach with community builders, local champions and volunteers integral to delivery as a result of the need to promote culture change. Three of the most successful current public health interventions are PALS, Health Trainers and Auntie Pams. All are rooted in communities, use a network of volunteers, promote resilience and self-care and are essentially social learning interventions that increase the confidence of users to develop their whole being and think more widely than the issues that have initially motivated them to attend the services in question.

3. HEALTH IN KIRKLEES – A REMINDER

- The average life expectancy in Kirklees is 79 for men and 83 for women, lower than the England average. Healthy life expectancy is also lower.
- In 2015 men living in the most deprived areas of Kirklees could expect to die 9 years before those living in the least deprived, the gap for women is 6.3 years.
- 70% of deaths before 70 years of age are considered preventable.
- Two thirds of the adult population are overweight and/or obese (66%, up from 62% in 2012) as well as one third of children aged 11.
- Kirklees has more physically inactive people and fewer active people than the English and West Yorkshire averages.
- Diabetes mortality is significantly higher than the England average and increasing
- Emotional health and wellbeing remains a major concern across all age groups.
- 1 in 4 people have one or more long term condition and the number is rising

These are system-wide issues requiring a system-wide response. Tackling them has been compounded by the silo-based approach to the commissioning and provision of health prevention services based on single issues and by single organisations e.g. smoking, obesity. Currently services are provided by a range of organisations, in a variety of different locations, with individual contact numbers and different methods of access. Professionals and the public are often unaware of the full range of services on offer due to the complexity of navigating pathways through services. Whilst there are some people that might need single issue support, many service users present with more than one issue and skills for the promotion of behaviour change are common ones that can be applied generally to health improvement and self-care if the right training and support is provided.

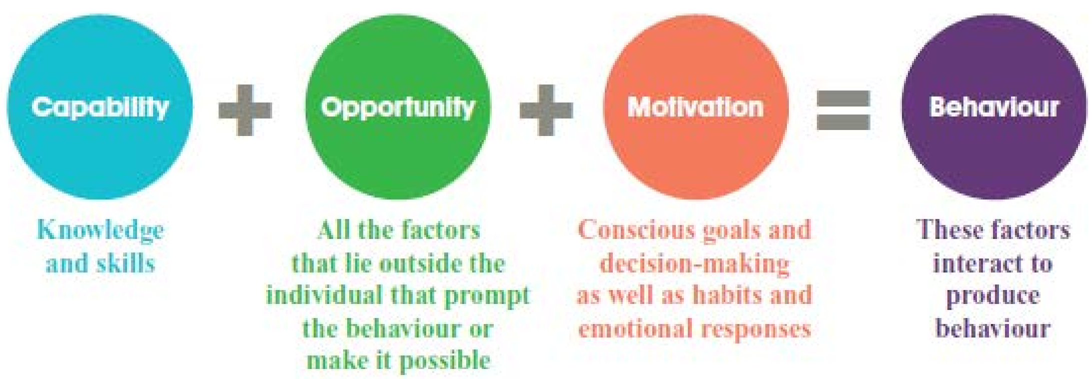
4. EVIDENCE BASE AND COST EFFECTIVENESS

Researchers have identified three main components that need to be present to influence behaviour (NESTA, 2016, see Figure 1 below). Whilst knowledge and skills are a key starting point, the great majority of, for example, obese people know that moving more often and eating a better diet is necessary. Opportunity, driven by wider factors, and motivation, influenced by culture and habits are at least as influential. The importance of wider factors and cultures that lie outside the immediate control of the individual demonstrate why a system-wide approach rooted in an integrated model is more likely to exert positive influences on individuals and populations than a silo-based approach to health improvement. With the wellness model, although a number of interventions are embedded, the same background awareness of the influences on behaviour are present and the staff work out which aspects of behaviour needs to be changed for each individual and a tailored programme developed.

The Liverpool Public Health Observatory review of wellness approaches concluded that they "*showed potential to give a return on investment and save future costs due to ill health. Some initiatives not only made savings in care costs, but improved quality of life, enabling individuals to live independently".* The report also found that wellness services could provide an effective longer term response to frequent attendees in primary care by tackling the underlying causes of their visits. Many of the services (such as social prescribing where patients are linked to the non-medical facilities and services available in their wider community) had low costs when compared to medical treatment (Public Health England/JMU 2012). Since 2012 other areas have adopted this approach, in particular the North East of England (Sunderland, Gateshead, Tyneside, Durham have all integrated services to a greater or lesser extent). Research is ongoing in each area but initial findings are positive. Public Health England has proposed the development of a community of practice approach

in West Yorkshire as Leeds and Calderdale are also considering this approach. Nonetheless, it is acknowledged by the Kings Fund (2015) "that because of the shortages of academic research evidence on the usefulness and cost-effectiveness of different approaches, commissioners will need to innovate and take risks”. Because there is no national blue-print for this project, Kirklees commissioners and providers have an opportunity to develop a cutting edge approach that seeks to meet the requirements of a wide range of partners and improves outcomes across our diverse communities.

Figure 1: Influences on behaviour (Michie, Atkins and West, 2014)



5. AIMS, OBJECTIVES AND DESIGN PRINCIPLES

5.1 Aim

The proposed aim is *“to support people to live longer, healthier, happier lives through greater integration and by moving resources towards a life-course based approach rooted in prevention and early intervention and away from avoidable treatment and care”.*

5.2 Design Principles underpinning the process

- Improved health and wellbeing
- Supporting independence, promoting resilience; helping people do more for themselves and each other
- Enabling healthy behaviours and reducing inequalities across the life-course
- Prevention and early intervention
- Self-care and better management of existing long term conditions, preventing these conditions worsening and utilising community focused approaches as well as preventative medicine
- Strengths and assets based approach to communities
- Collaboration and integration and clear pathways at all levels
- Intelligence and insight led
- Evidence based without hampering creative approaches and innovation
- Embedding behaviour change approaches that utilise the most effective behaviour change techniques tailored to each individual
- Long term thinking and planning horizons

5.3 Wellness Model Strategic Outcomes

The Wellness Model will support the aims of New Council to empower people to live their lives to the fullest possible potential by enabling people to increase control over their health through making changes to their lives. It will support the NHS 5 Year Forward View and Sustainability and Transformation Plans by diverting people from primary and secondary healthcare services towards prevention pathways, helping to contain rising healthcare costs. Pathways will be streamlined and consideration will be given to self-referral, drop-in and outreach approaches.

5.4 Integration

The primary objective of the Wellness Model is to provide a person centred, integrated, single point of access wellness service within a wider wellness network. The services that might, after partner discussion, be included are|:

- Diet and nutrition
- Physical activity and exercise on prescription
- Weight management and diabetes prevention
- Tobacco/smoking cessation
- Alcohol early intervention?
- Mental wellbeing and links to IAPT and personal resilience
- Self-care including Expert Patient Programme
- NHS Health Checks (based in primary care)
- Health trainers
- Volunteer Community Health Champions
- Health psychology and behavioural insights
- Promoting cancer prevention and engagement with screening
- Social marketing and community insight
- Digital health improvement

Other services integral to the wider model:

- Services for vulnerable adults (drugs, domestic abuse, offender health etc)
- Planned care e.g. pain services
- Proposed national diabetes prevention service
- Carers services and recovery services
- Social prescribing (Better in Kirklees etc)
- Schools as community hubs

Strong links to systems tackling wider factors influencing health within the model:

- Communities – including community development, sporting and third sector
- Healthy environments – leisure, parks/open spaces, active travel, food growing
- Housing advice and support – all tenures
- Employment advice and support
- Anti-poverty approaches including food banks, proposed credit union

6. DELIVERY OPTIONS

Whilst the overall design emphasises the importance of the broader partnership model consideration needs to be given to the approach to commissioning. Four possible service delivery models could be investigated for options appraisal:

- Maintain current service provision under several providers (no change option)
- Establish a virtual Wellness Service with several providers in a clearer collaboration based approach. Model and service would be 'emergent' and build on existing strengths/relationships
- Establish a fully integrated Wellness Service by bringing together existing lifestyle services under a lead provider model with sub-contracted specialist provision where necessary
- Establish a fully integrated service under a single provider

Other areas have opted for the second and third of these options. Some have instigated a "year zero" type approach and ended a series of contracts, others have taken an approach based on aligning contract end dates. Most existing Public Health contracts end in October 2017 and March 2018. A pragmatic approach would be to plan an approach in which different components of the service go live at different points in time, with the full approach going live on 1 April 2018.

7. NEXT STEPS

7.1 Determine Governance – it is proposed that a partnership project board is set up, chaired by the Project Sponsor (TBC) with representation from CCGs, Council EIP Programme, Healthwatch, Public Health, Community Engagement, Third sector leaders group, Communications. The Wellness project board would report via the new Health Improvement Integrated Commissioning Group to the Health and Wellbeing Board and CCG Governing Bodies. Procurement, legal, HR and finance support would be utilised as necessary.

7.2 Insight and engagement with public and providers - a public engagement exercise should be undertaken to ensure that resident needs are defined and used to inform the design process for the Wellness Service, as well as obtaining insight into community perceptions of potential approaches. Likewise, insight from existing and potential new providers will be important to generate mutual understanding about what may or may not be the best options for Kirklees.

7.3 Understand risks – initial conversations with other commissioners elsewhere in the country have outlined service related risks related to thresholds of intervention, attracting the worried well, a universal vs targeted approach. System issues appear to concern marketing, branding and ownership across the health and social care system, not losing added value inherent in (some) existing interventions and losing organisational memory.

7.4 Leadership and management – the Head of Health Improvement would lead the process reporting to the Project Sponsor, determining the resources needed to manage the process of designing the wellness model. A Project Initiation Document will be drafted with clear timelines between April 2016 and April 2018.

Tony Cooke, Head of Health Improvement, June 2016.

KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**Thursday 30 June 2016**
TITLE OF PAPER:	**Health Protection Board Update**

1. Purpose of paper

This is a planned update to the Health and Wellbeing Board on the work of its subcommittee, the Health Protection Board. The last update was made in October 2015.

2. Background

Following issues given in previous reports, the Health Protection Board would like to update on the following areas:

- Tuberculosis
- Screening and immunisation
- Antimicrobial Stewardship

3. Proposal

3.1 Tuberculosis (TB)

TB has also been considered by the Overview and Scrutiny Panel for Health and Social Care, with its most recent update and discussion in April 2016.

Latent TB Screening

The TB strategy recommends latent TB infection (LTBI) testing and treatment for 16 to 35 year olds who have recently arrived in England from countries where the TB incidence is 150/100,000 population or over. NHS England has made funding available to support the implementation in areas with a high TB incidence. Kirklees was one of the six CCG areas across Yorkshire and the Humber that could submit a bid. NHS Greater Huddersfield CCG and NHS North Kirklees CCG were both successful in obtaining funding. LTBI can be diagnosed by a single blood test and is usually treated with antibiotics to prevent active TB disease in the future. LTBI testing and treatment of new entrants is supported by National Institute of Health and Care Excellence.

Kirklees CCGs received funding from NHS England and started testing people eligible for this programme in February of this year via existing community TB service providers. The two CCGs were also recently notified that this funding will be continued in the next financial year (2016/17), and it is expected that this funding will continue for the lifetime of the strategy.

TB Control Board

In order to ensure clear responsibility and accountability arrangements, TB Control Boards have been established to serve defined geographical areas. The TB Control Board serving Kirklees covers Yorkshire and Humber and North East of England (YHNE). The group is a high level Board chaired by the PHE TB lead for Yorkshire and Humber, supported by a TB Programme Manager.

The role of the YHNE TB Control Board is to plan, oversee, support and monitor all aspects of local TB control. It covers clinical and public health services, workforce planning, and the appropriate commissioning of TB services. Through collaborative working and the use of existing accountability arrangements, the TB Control Board will hold providers and commissioners to account.

Greater Huddersfield CCG is the lead CCG representative on the board. The board also includes representation from PHE, NHS England, local authority directors of public health and social care, the NHS (primary and secondary care, adult and paediatric TB specialists and front line nursing representation) and

the third sector.

Kirklees TB Strategy Group

Kirklees TB Strategy Group is chaired by the Director of Public Health. This group brings together partner organisations, services and stakeholders locally and sets a clear direction for improved services. The principle purpose of the group is to bring together representatives from across the health and social care economy to help ensure effective commissioning and development of services locally, in order to support work to reduce the incidence of TB.

3.2 Screening and Immunisation

A screening and immunisation improvement plan has been developed for Kirklees. This has been partnership work done with NHS England, CCGs and Kirklees Council Public Health. It aims to address issues such as the continuing decline in cervical screening uptake, and included initiatives/media messages around the cervical screening awareness week in June.

The Diabetic Eye Screening Programmes (DESP) have been recently out for tender. The service has been procured in two lots:

- Lot 1 (Leeds, Wakefield, North Kirklees) – awarded to Mid Yorkshire Hospitals Trust
- Lot 2 (Calderdale, Greater Huddersfield, Bradford and Airedale) – awarded to Emis Care Ltd.

Both services will mobilise to begin delivery on 1st April 2017.

NHS England is responsible for commissioning the screening and immunisation programmes. It established West Yorkshire Screening and Immunisation Oversight Group (WYSIOG) to provide assurance and a strategic overview across West Yorkshire. This group is now meeting regularly, it has Kirklees Council Public Health representation and the concerns that have previously been raised at HWB are no longer an issue. Staff in NHS England/PHE screening and immunisation team continue attending the Health Protection Board and other local meetings as needed to develop work in Kirklees.

3.3 Antimicrobial stewardship

This was a major focus at the December HPB meeting, with updates from both CCGs, Locala, MYHT and CHFT. Much is being done in all the different organisations to address this important priority. Connections have been made with the Area Prescribing Committee (Calderdale, Kirklees and Wakefield) work as it was being reviewed, and also PHE.

North Kirklees and Greater Huddersfield CCGs have adopted a system wide approach to promoting and monitoring the use of antimicrobials. Both CCGs have made significant reductions in the last few years in the volume of Cephalosporin and Quinolone antibiotics used and have managed to maintain levels well below the England average for over two years.

Antibiotic campaign

In April 2015 a multi-disciplinary working group across Calderdale, Kirklees and Wakefield was set up to develop an antibiotic campaign starting in September 2015. This aimed to reduce unnecessary prescribing of antibiotics by raising the awareness of the risks of over-prescribing and antimicrobial resistance. It targeted GP practices, pharmacies, members of the public and CCG staff. The focus was three key messages:

1. Become an Antibiotic Guardian.
2. Antibiotics don't work on self-limiting conditions.
3. Promote self-care.

Engagement with community pharmacy was through partnership working with Community Pharmacy West Yorkshire (CPWY). Posters and scratch cards, designed to be used as a fun way of engaging the public in conversations about antibiotic resistance, were sent out to all pharmacies in WY. A competition was made

by Y&H Academic Health Science Network for pharmacies demonstrating innovative ways to use the campaign resources.

Public messages included:

- A live radio broadcast on Al-Mubarak radio (based in Batley) was aired on the 18th November. The station has an active social media presence and 70% of the listeners are in Yorkshire. The antibiotic guardian video was played on their news feed and sent out the links via their twitter account. The broadcast covered flu, staying well over winter, self-care and antibiotics and was delivered by a North Kirklees GP, Public Health Head of Health Protection and a Community Pharmacist.
- One of the North Kirklees pharmacists also delivered several educational sessions in local mosques.

Awards

The multi-disciplinary working group entered for the national 2016 Antibiotic Guardian awards. The collective group (GHCCG, NKCCG, Calderdale CCG, Wakefield CCG, Community Pharmacy West Yorkshire and Kirklees and Wakefield Infection and Prevention Control Team) won the Collaborative Stewardship Category Award. NKCCG were also highly commended in the Community Category.

Clostridium difficile infection

A Clostridium difficile infection (CDI) summit was held on 19th April 2016 across the MYHT footprint with a partnership approach to reduce CDI infections and agree future work and actions. Antibiotic exposure is the major risk factor for the development of CDI. We are looking to replicate this summit across the CHFT footprint also.

4. Financial Implications

Nil

5. Sign off

Rachel Spencer-Henshall, Director of Public Health
16th May 2016

6. Next Steps

The Health Protection Board plans to continue meeting quarterly in order to maintain an overview and gain assurance of health protection issues in Kirklees on behalf of the HWB. This also facilitates working relationships across organisations and enables partners to progress needed work more effectively.

7. Recommendations

1. The Health and Wellbeing Board notes the information given above
2. The Health and Wellbeing Board encourages partner organisations to continue working together, and in particular look at developing even closer ongoing co-ordination in the area of antimicrobial stewardship.

8. Contact Officers

Dr Mercy Vergis,
Consultant in Public Health
Kirklees Council
mercy.vergis@kirklees.gov.uk

Jane O'Donnell,
Head of Health Protection
Kirklees Council
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KIRKLEES HEALTH & WELLBEING BOARD	
MEETING DATE:	**30th June 2016**
TITLE OF PAPER:	**Kirklees Health and Wellbeing Board Position Statement: Proposals for major health and social care service changes affecting Kirklees**

1. Purpose of paper

To seek the Board's approval of the attached Position Statement with regard to 'Proposals for major health and social service changes affecting Kirklees'.

To seek the Board's support for further development of joint working between key partner organisations, and partnership bodies with statutory responsibilities linked to health, social care and wellbeing especially Overview and Scrutiny, Healthwatch, the Children's and Adults Safeguarding Boards, and the Safer Stronger Board.

2. Background

Since the Board's inception it has regularly discussed a wide range of major health and social care service changes that affect Kirklees. These have included in the last 12 months; Right Care Right Time Right Place, Meeting the Challenge, Care Closer to Home, Better Care Fund, the Council's approach to early intervention and prevention, West Yorkshire Emergency Care Vanguard, Children's Emotional Wellbeing Transformation Plan, Stronger Families, services for children with a disability and the Healthy Child Programme.

The Board endorsed a set of proposed amendments to its Terms of Reference at the April 2016 meeting. The amended purpose and function of the Board includes;

- To provide the structure for overseeing local planning and accountabilities for health and wellbeing related services and interventions and the development of integrated sustainable health and social care systems.
- To provide assurance that the commissioning and delivery of plans of partners have taken sufficient account of the Joint Health and Wellbeing Strategy and the Joint Strategic Needs Assessment.
- To provide leadership and oversight of key strategic programmes, such as the Sustainability and Transformation Plan, Better Care Fund, and to encourage use of associated fund arrangements where appropriate.

These proposed amendments were agreed at the Council Annual General Meeting on 25th May 2016.

The local governance and decision making landscape for health and social care is complex. In light of this complexity the Board discussed the development of a joint working protocol between the Board, Overview and Scrutiny and Healthwatch in 2015. There have been subsequent discussions with the Children's and Adult Safeguarding Boards and the Safer Stronger Board about developing a similar joint working protocol, and this work needs to be concluded. The main purpose of these protocols is to ensure that there are positive and constructive working relationships between the respective bodies, and clarity about their respective roles.

3. Proposal

The attached Position Statement with regard to 'Proposals for major health and social care service changes affecting Kirklees' builds on this work and seeks to clarify the Board's expectations around any proposals for major health and social care service changes and associated consultation processes. If the Board adopts this position statement it will provide a framework within which it can apply the '4 tests' to proposals for major service changes that are presented to the Board.

In view of the revised purpose and function of the Board and the complexity of the governance and decision making landscape for health and social care it is essential that the Board develop positive and constructive working relationships with both key partner organisations, and partnership bodies with statutory responsibilities linked to health, social care and wellbeing. Without continuing to build these positive working relationships the '4 tests' will not be built into the early stages of thinking about potential service changes.

4. Financial Implications

None

5. Sign off

Richard Parry, Director for Commissioning, Public Health and Adult Social Care, Kirklees Council

7. Recommendations

That the Board

- adopt the 'Position Statement - Proposals for major health and care social service changes affecting Kirklees'.
- encourage all partners involved in major health and care social service changes to use the Position Statement and the '4 tests' to inform their commissioning and planning activity and the associated assurance processes.
- support the further development of joint working with key partner organisations, and partnership bodies with statutory responsibilities linked to health, social care and wellbeing especially Overview and Scrutiny, Healthwatch, the Children's and Adults Safeguarding Boards, and the Safer Stronger Board.

8. Contact Officer

Phil Longworth, Health Policy Officer, Kirklees Council

phil.longworth@kirklees.gov.uk

Kirklees Health and Wellbeing Board Position Statement
Proposals for major health and social care service changes affecting Kirklees
May 2016

The Health and Wellbeing Board brings together senior leaders from the Council and NHS and has a statutory responsibility for ensuring that there is a Joint Strategic Assessment (JSA) and Joint Health and Wellbeing Strategy (JHWS).

The Board sets the shared strategy for health and wellbeing of everyone in Kirklees through the JHWS, ensuring that the Strategy addresses the findings of the JSA. The JHWS vision is that by 2020

> *No matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality.*

The Strategy is based on a set of principles that should inform the implementation of the strategy and the overall direction of service changes. A key principle is taking a person centred view of the outcomes we are trying to achieve and that any changes to the way the local health and social care system works should enable people to better meet their own goals and aspirations. The commitment to developing a sustainable health and social care system must be delivered in a way that supports these principles. The Board also has a role in testing proposals against the strategy, principles and overall direction of service change.

The Board welcomes the commitment from all partners to undertake formal engagement processes for large scale changes, and will work with partners to ensure everyone can contribute appropriately to these processes.

The Board will receive and discuss regular updates on progress throughout the process. The Board expects comments at the Board and representations to the Board to be fed into the formal consultation process and across to the relevant Overview and Scrutiny Panel.

The Board recognises the statutory role of Overview and Scrutiny in scrutinising proposed service changes and the impact these will have in terms of; patient/user outcomes, access to services including travel, views of local people and the impact on the local health and social care economy.

The Board also recognises the role of Healthwatch as the 'consumer voice', and the work it undertakes to ensure the views of local people are a vital part of any consultation process.

The Board is taking the lead on the development of a five year Sustainability and Transformation Plan (STP) for Kirklees that will set out our approach to driving forward the NHS Five Year Forward View. The STP will be published in Autumn 2016 and provide the framework for major changes over the next few years.

Therefore the Board will seek to assure itself that any proposals for major service changes and associated consultation processes meet the following 4 tests.

That the proposals

1. **Reflect the JHWS particularly the outcomes for the Kirklees population and the system change principles with its strong emphasis on prevention and early intervention, and the key health issues identified in the JSA**
2. **Take into account the implications across the Kirklees health and social care system**
3. **Enable local people to actively engage in the consultation process in a meaningful way**
4. **Maximise their contribution to the Kirklees Sustainability and Transformation Plan.**

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Name of meeting: Health and Wellbeing Board

Date: 30 June 2016

Title of report: Re-establishment of Child Sexual Exploitation and Safeguarding Member Panel for the 2016/17 Municipal Year

Is it likely to result in spending or saving £250k or more, or to have a significant effect on two or more electoral wards?	No
Is it in the Council's Forward Plan?	No
Is it eligible for "call in" by Scrutiny?	Yes
Date signed off by Director & name Is it signed off by the Director of Resources? Is it signed off by the Assistant Director - Legal & Governance?	David Smith – 18th April 2016 As above Julie Muscroft – 13th May 2016
Cabinet member portfolio	Family Support and Child Protection

Electoral wards affected: N/A
Ward councillors consulted: N/A
Public or private: Public

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1. **Purpose of report**

1.1 To seek the Health and Wellbeing Board's formal agreement for the re-establishment of the Child Sexual Exploitation and Safeguarding Member Panel for the 2016/17 Municipal Year and agree the Kirklees Council representation.

2. **Key points**

2.1 At the beginning of the new Municipal Year Health and Wellbeing Board is asked to agree the re-establishment of the Child Sexual Exploitation and Safeguarding Member Panel for the 2016/17 Municipal Year and agree the Kirklees Council representation on the Panel.

3. **Background**

3.1 The Council meeting on 10th December 2014 considered the proposed constitutional changes and agreed the following:-

- Council approved the Terms of Reference of the Child Sexual Exploitation and Safeguarding Member Panel (attached at appendix 1).

- Agreed that the frequency of the meetings of the Child Sexual Exploitation and Safeguarding Member Panel be no less than those of the Kirklees Safeguarding Board; and

- That the minutes should be submitted to the meetings of the Health and Wellbeing Board.

3.2 Council agreed that the Panel should comprise of 5 members i.e. one member from each of the political groups on the Council plus the Cabinet Member with statutory responsibility.

4. Implications for the Council

4.1 There are no specific implications at this time.

5. Consultees and their opinions

5.2 Not applicable.

6. Next steps

6.1 Subject to the agreement of the Health and Wellbeing Board, the intention is for officers to start the process of seeking nominations for representation on the Child Sexual Exploitation and Safeguarding Member Panel.

7. Officer recommendations and reasons

7.1 That Health and Wellbeing Board agrees to the proposal that nominations from Kirklees Council for appointment to the Child Sexual Exploitation and Safeguarding Member Panel reflect the original decision of Council and that the Panel comprise of 5 members, ie one from each of the political groups on the Council plus the Cabinet Member with statutory responsibility.

7.2 That Health and Wellbeing Board agrees to the re-establishment of the Child Sexual Exploitation and Safeguarding Member Panel and agrees to the Kirklees membership, as outlined in 7.1 above.

8. Cabinet portfolio holder recommendation
Not applicable.

9. Contact officer and relevant papers
Helen Kilroy, Principal Governance and Democratic Engagement Officer, Tel: 01484 22916 email: helen.kilroy@kirklees.gov.uk

10. Assistant director responsible
Julie Muscroft, Assistant Director Legal Governance and Monitoring

APPENDIX 1

Child Sexual Exploitation and Safeguarding Member Panel – Terms of Reference

Purpose of the Panel:

- To oversee local developments in the monitoring of, and response to, the risks associated with Child Sexual Exploitation.
- To satisfy themselves, as corporate parents, that the arrangements for safeguarding looked after children in Kirklees are sufficiently robust.
- To ensure that, where appropriate and having regard to confidentiality requirements, individual members of the Panel ensure that feedback is provided to members of their wider political groups.

Membership:

- The Panel should comprise of 5 members i.e. one member from each of the political groups on the Council plus the Cabinet Member with statutory responsibility.
- Each of the political groups can nominate a named observer to be on the Panel. That Member would be the same on each occasion and will be required to abide by the rules of confidentiality within the terms of reference.
- Each Member of the Panel or the Group Business Manager can give advance notice of a substitution to attend the Panel. That Member would be the same on each occasion where possible and abide by the rules of confidentiality within the terms of reference.

Governance Arrangements for the Panel:

- Meetings will be four weekly.
- All meetings will take place in private.
- All members are bound by the confidentiality requirements which apply to the Safeguarding Boards and will need to sign an undertaking as such.
- The Health and Well Being Board is the parent committee for the Panel. The Panel will, as appropriate, report on progress and emerging issues to the Health and Well Being Board in the first instance.

Overview and Scrutiny:

- Given the cross cutting nature of Child Sexual Exploitation and Safeguarding it is noted that Overview and Scrutiny Management Committee will put in place appropriate overview and scrutiny arrangements.

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Annual report and accounts 2015/16

For longer, healthier, happier lives

Contents

	Page
Performance report	3
Overview	4
Chief officer's statement	4
About us	5
Performance analysis	9
Year in focus	9
Sustainability report	16
Operating and financial review	17
Accountability report	21
Corporate governance report	22
Members' report	22
Statement of accountable officer's responsibilities	27
Governance statement	28
Remuneration and staff report	48
Remuneration policy	49
Salaries and allowances	51
Independent auditor's report	61
Financial statements	64
Appendix 1	66

PERFORMANCE REPORT

Overview

Chief officer's statement

This has been a successful yet challenging year for NHS North Kirklees Clinical Commissioning Group (CCG). We reached a significant milestone in our plan to ensure that more healthcare is delivered outside of hospital with the award of the 'care closer to home' contract to Batley-based social enterprise Locala Community Partnerships, working with South West Yorkshire Partnership NHS Foundation Trust.

Together with partners across Kirklees we developed a transformational approach to child and adolescent mental health services which has already secured additional funding and will lead to much needed improvement in local provision over the coming years.

The development of a new primary care strategy will support local GP practices to address workforce challenges and develop their services to meet the changing needs of the North Kirklees population. The establishment of a CCG Council of Members will support engagement with our GP membership.

A successful bid to NHS England for 'vanguard' support means that we can take an innovative, West Yorkshire approach to the improvement of urgent and emergency care services over the coming years.

Discussions with neighbouring NHS Greater Huddersfield CCG and Kirklees Council have progressed over the year and we are now working together to commission a range of services across health and social care.

However, during 2015/16 the CCG continued to face a range of challenges arising from changes in local health and social care needs, population growth, continued financial pressure and workforce issues. In response, we have started to talk to local people, our GP members and other partners and stakeholders about how we can continue to maintain and improve services across North Kirklees. These discussions will continue into the next financial period.

As I step down from my post as Chief Officer at the end of this financial year, I would like to thank everyone who has supported me over the past three years including CCG staff, Governing Body, GPs and many other local stakeholders and individuals. The organisation has achieved a great deal since it was established and I know that it will continue its work, under the leadership of my successor, Richard Parry, to ensure that local people receive the best possible healthcare in the future.

Chris Dowse
Chief Officer

About us

NHS North Kirklees CCG was established and fully authorised as a statutory body on 1 April 2013 and became responsible for the planning and purchasing (commissioning) of local healthcare services on behalf of patients registered in the North Kirklees area. This is our third Annual Report and Accounts following the accounts direction within the Health and Social Care Act 2012.

The CCG commissions a range of services including:

- Emergency and urgent health care
- Ambulance services
- Community health services such as community nursing, physiotherapy, occupational therapy, and chiropody
- Maternity services
- Hospital care such as outpatient and inpatient services and planned operations
- Rehabilitation services
- Specialist services for those with mental health conditions and learning disabilities
- Prescriptions for medicines signed by doctors at GP practices across North Kirklees.

The CCG serves a population of around 190,000 people across Dewsbury, Batley, Mirfield, Heckmondwike, Cleckheaton, Birstall, Liversedge and Ravensthorpe and has an annual budget in the region of £243 million.

We are a membership organisation comprising 29 GP practices. The CCG is clinically-led, which means that health professionals are actively involved in the development of strategies as well as in day-to-day decision making. The CCG Governing Body includes six general practitioners, a secondary care (hospital) consultant and three nurses, as well as those with other specialist knowledge and expertise.

We work closely with health and social care partners and providers such as The Mid Yorkshire Hospitals NHS Trust, South West Yorkshire Partnership NHS Foundation Trust, Locala Community Partnerships and Kirklees Council. Many of our services are commissioned jointly with NHS Wakefield CCG, NHS Greater Huddersfield CCG or collaboratively with CCG partners across West

Yorkshire. We have an excellent relationship with Healthwatch Kirklees and are developing effective links with local community and voluntary groups.

Vision and values

Our vision is to enable local people to live longer, healthier and happier lives. This lies at the heart of everything we do and every decision we make. Our work is guided by five key values:

- Patient first
- Strive for excellence
- Value each other
- Lead from every seat
- Engage, involve and include.

Challenges and priorities

The Kirklees area is a rich mix of urban and rural communities and local residents often have a strong sense of attachment to their home town or village. Kirklees has a diverse population with 21% giving their ethnicity as non-white in the 2011 census. The largest group of non-white residents comprises people of South Asian origin. The birth rate in the region is higher than the English average and life expectancy is lower. An increasing number of local people are living with long-term health conditions. North Kirklees includes some of the most deprived localities in the borough and there are a range of health inequalities.

Overall, health and wellbeing in Kirklees has improved over recent years, but not for all groups. For example, men and women in Dewsbury have a life expectancy of 5 and 3.6 years respectively shorter than those in the Holme Valley. The growing population, especially the sharp rise predicted in the number of older people; the difficult economic climate and the local picture of ill health and inequality ensures that we are operating in a challenging environment.

Our plans for the future must reflect the needs and aspirations of local people and address identified health inequalities. It’s also important that our population has access to the most up to date technologies and that healthcare is delivered in line with the latest guidance. In addition, we know that we must work closely with Kirklees Council and other local CCGs to develop a more joined-up approach to health and social care.

We also have to be realistic about the financial and other constraints that face the NHS both nationally and in our area. Working with local people, partners and stakeholders, we have identified a range of transformational health priorities which are outlined below. These are described in more detail in our two year operational plan and five year strategic plan, which are published on our website.

Care closer to home

We want as much healthcare as possible to be delivered in people's homes or closer to where they live. We believe that moving more care into the community will encourage independence, give people greater choice and control, improve their experience and provide better flexibility and access to health services. It will also help us to manage increasing demand for hospital care.

Transforming general practice

Our vision is to create excellent general practice within North Kirklees that will provide high quality and choice for patients and attract the most talented and experienced healthcare professionals to the area. If we are to deliver as much care as possible out of hospital, closer to patients' homes, we must equip our general practices to provide the modern, responsive and integrated services people need.

Improving hospital services

We will ensure that there is a vibrant hospital in Dewsbury, providing as much local care as possible, delivered alongside excellent community services. By 2017, more people will be using services in Dewsbury and District Hospital than at present. The number and range of planned operations, outpatient appointments and diagnostic tests offered at Dewsbury will increase and all outpatient appointments will be offered locally where this is clinically appropriate. Specialist and complex care will be centralised at Pinderfields General Hospital. This will improve quality and safety by ensuring that there are sufficient skilled staff with the right resources around them to provide care 24 hours a day, seven days a week.

Urgent and emergency care

Urgent and emergency services provide life-saving care. Our vision is to develop high quality urgent and emergency care services that deliver the best outcomes for local people. To do this, we need to make sure that patients access the right service, in the right place at the right time for their needs.

Engagement and partnership

We work in partnership with local NHS organisations such as hospitals and neighbouring CCGs, local voluntary sector organisations, community groups and Healthwatch Kirklees to identify the health needs of the community we serve and then to plan and buy services.

We contribute to the development of the Kirklees Joint Strategic Health Needs Assessment (JSNA) and its findings contribute towards our work programmes. This ensures that as commissioners, we are addressing the health and social needs of the population we serve.

Working with our partners and the Health and Wellbeing Board we have developed our plans for the Better Care Fund. This is a pooled budget shared by NHS North Kirklees CCG, Kirklees Council and NHS Greater Huddersfield CCG. The fund uses existing monies to promote integration across the health and social care system and is governed by the Health and Wellbeing Board. Our plans were approved for implementation in December 2014 and are refreshed annually.

Our five year strategic plan has been developed collaboratively with NHS Greater Huddersfield CCG and Kirklees Council. Working through the Health and Wellbeing Board and the Integrated Commissioning Executive we ensure that the commissioning priorities for health and social care across Kirklees are aligned. During the year we continued to explore ways in which we could take a more integrated approach to health and social care commissioning in a number of key areas.

Some specialist services such as urgent and emergency care, cancer, stroke, primary care and paediatrics are considered or commissioned by CCGs across West Yorkshire and Harrogate working in collaboration.

In line with the duties identified in the Health and Social Care Act 2012 in relation to public involvement and consultation, we seek the views of patients, carers and the public through mechanisms ranging from attendance at events and meetings to more formal engagement and consultation activities. Our engagement and involvement work is not simply about meeting our statutory duties, but aims to reflect the value and benefit of putting patients and the public at the heart of the commissioning process.

Working with our membership

The CCG works closely with its 29 member GP practices to ensure involvement in the commissioning process. We have identified clinical leads for key programmes of work, held monthly GP and

practice nurse forums, and have established a range of committees and working groups which benefit from clinical input. A Council of Members was established in March 2016 with the overall purpose of representing the views of GP member practices as advocates of their patients.

Listening to local people

By listening to local people and those who represent them, we can improve the decisions we make, ensure we are considering the health needs and aspirations of North Kirklees residents and meet our statutory duties in relation to consultation. We've developed a range of ways for people to find out more about our work and have their say about local health services. Full details are published on our website.

Working with Kirklees health and wellbeing board

The Health and Social Care Act 2012 established health and wellbeing boards as a forum where key leaders from the health and social care systems work together to improve the health and wellbeing of their local population and reduce health inequalities. Health and wellbeing board members collaborate to understand their local community's needs, agree priorities and encourage commissioners to work in a more joined-up way. As a result, patients and the public should experience more integrated services from the NHS and local councils.

Performance analysis

The year in focus

Throughout the year, we have worked with a range of partners, patients and the public to develop and improve health services for local people, in line with legal duties under section 14R of the Health and Social Care Act 2012 and our strategic plan.

Together with The Mid Yorkshire Hospitals NHS Trust and NHS Wakefield CCG we continued to implement our Meeting the Challenge programme, which is designed to deliver significant improvements in hospital care and better outcomes for patients.

From August 2015, all specialist and emergency heart services are being delivered from a single coronary care unit based at Pinderfields Hospital in Wakefield. This ensures the most critically ill

patients get quicker access to the specialist care they need, 24 hours a day seven days a week. The change is in line with British Cardiovascular Society recommendations.

A £20 million re-development of the Dewsbury and District Hospital site got underway in December when construction started on a new birthing centre. The £1.5 million unit is on schedule to open in the summer of 2016.

The number of clinics and specialties at Dewsbury and District Hospital is increasing as part of a phased programme of work. Up to August 2016, the hospital trust plans to deliver 30 more clinics from the site. Further clinics will be available at Dewsbury once the re-development of the estate has been completed in 2017, when the equivalent of 20,000 more people will be able to have a local outpatient appointment.

Our ambition to deliver more care closer to home moved forward with the award of a contract for a wide range of community-based services to Locala Community Partnerships, working with South West Yorkshire Partnership NHS Foundation Trust. The Batley-based social enterprise and its partner is delivering a new model of care which includes:

- Community services available for longer during the evening and weekends
- Single care record, so people only have to tell their 'story' once
- Greater use of technology to provide faster access to support
- A single phone number for patients
- Integrated community teams health professionals
- Focus on helping patients to manage their own long-term conditions.

We continued to work with GP practices across North Kirklees to improve patient access, enhance quality and reduce the variability of care. A key area of work this year has been the development of a new primary care strategy. Building on discussions with our GP members, partners and patients, the strategy describes how the CCG will support and encourage practices to respond to the NHS Five Year Forward View and develop their services to meet changing needs.

Over the year, we developed a range of initiatives designed to support GP practices address workforce issues. These included: funding a training programme designed to develop the local practice nurse population; working with the Primary Care Training Centre and Health Education Yorkshire and Humber to develop training packages for practice staff; and supporting and

encouraging practice involvement in initiatives such as advanced clinical practitioners, clinical pharmacists and health care assistant apprenticeship schemes.

Working with GP federation, Curo Health Limited and Locala Community Partnerships we funded a pilot programme to provide clinical care co-ordinators to support people to stay in their own home or in an appropriate community setting, rather than visit hospital.

CCG Chief Officer Chris Dowse led a successful West Yorkshire bid for NHS 'vanguard' support for an innovative regional approach to urgent and emergency care. Vanguards are part of a national programme designed to encourage new models of healthcare. Commissioner and provider organisations across the region will work together over the next three years to develop a range of initiatives with support from the programme.

Our strong commitment to public and patient involvement was demonstrated through a range of activities during the year. We held four public engagement events including our Annual General Meeting; consulted with patients and other stakeholder on issues including personal health budgets, vasectomy, community gynaecology, musculoskeletal and GP services; and hosted four meetings of our Patient Reference Group Network.

The CCG worked with partners NHS Greater Huddersfield CCG and Kirklees Council to provide grants in support of health and social care projects including: a support network for people with cancer; drop-in sessions for those who are socially isolated; evening activities for young people with autistic spectrum conditions and special needs; and health awareness support for older men of South Asian origin.

Together with Kirklees Council and NHS Greater Huddersfield Clinical Commissioning Group we developed 'My Health Tools', an interactive website aimed at people living with long-term conditions.

We supported a range of national campaigns including *Stay Well this Winter* and promotions designed to encourage the correct use of antibiotics, increase knowledge about the symptoms of breast cancer and highlight the importance of blood pressure monitoring.

We continued to focus upon quality improvement over the course of the year and discharge our legal duty in this respect as evidenced by the following activities:

- Quality assurance and quality improvement work streams of all providers and our work as a commissioner was discussed and scrutinised at each Governing Body and Quality, Performance and Finance Committee meeting.
- We quality impact assessed all CCG procurements and quality was a key part of all new service specifications.
- We established a primary care quality and access group to ensure providers are supported and encouraged to adopt best practice and drive achievement clinical standards and quality.
- We worked collaboratively with neighbouring CCGs to undertake provider quality monitoring and assurance.
- We carried out a number of patient safety walkabouts within provider services.
- We worked with the Improvement Academy to support the implementation of safety huddles in the community with district nurses.

Key performance indicators [1]

We have used national measurements at a local level in order to provide an overview of how we are performing in North Kirklees. Throughout the year we have worked with partners and providers to gain a greater understanding of the factors impacting upon performance and where necessary, put plans in place to deliver required improvements. The achievement of performance targets continues to be a focus for the CCG.

Performance in relation to A&E waits, referral to treatment and cancer waiting times is monitored by The Mid Yorkshire Hospitals Trust Board and Executive Board, Performance and Service Group and Access Group. In addition, working collaboratively with neighbouring NHS Wakefield CCG we have organised a series of performance summits involving NHS England and the Trust Development Agency to gain a greater understanding of the issues affecting performance and to work collectively to deliver improvement. Through the local Systems Resilience Group a concordat agreement is now in place to deliver an emergency care improvement programme action plan.

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[1] *Unless otherwise stated, performance data is as at 31 December 2015.*

Ambulance service performance continues to be monitored by the Yorkshire Ambulance Service West Yorkshire Contract Management Board. Regular performance summits are held in order to gain a shared understanding of the issues affecting performance and support plans to secure improvement.

Ambulance performance

National assessment of the ambulance response times metrics is against Yorkshire Ambulance Service NHS Trust overall performance achievement.

Category A (Red 1 and Red 2) ambulance calls are those classed as life threatening. The national standard requires that 75% of calls should receive a response within eight minutes and 95% of calls within 19 minutes. This standard has not been achieved for most CCGs across West Yorkshire, including North Kirklees during 2015. Yorkshire Ambulance Service NHS Trust performance shows:

% response to Category A Red 1 calls within 8 minutes: Target 75% Actual 69.0%

% response to Category A Red 2 Calls within 8 minutes: Target 75% Actual 71.0%

% response to Category A Red 1 & R2 calls within 19 minutes: Target 95% Actual 93.9%

The timely handover of care between ambulance and A&E services is essential in order to secure the delivery of high quality patient care. In line with the national target for ambulance handover times, it is expected that all handovers between ambulance and A&E services will take place within 15 minutes. Yorkshire Ambulance Service NHS Trust performance shows:

Ambulance handover delays within 15 minutes: 62.7%

Crew Clear delays within 15 minutes: 83.9%

Cancer waiting times

National cancer waiting times require that no-one should wait more than 31 days for a second or subsequent cancer treatment and no-one should wait more than 61 days from referral to treatment through National Screening Programmes or by hospital specialists.

We have worked with partners to ensure the sustained delivery of a maximum waiting time of two weeks from GP referral to first outpatient appointment for all urgent suspected cancer referrals; one

month from diagnosis to treatment for all cancers; and two months from urgent referral to treatment for all cancers.

The NHS will continue to play a major role in public health, both in terms of delivering specific health programmes such as immunisations or screening, as well as in maximising opportunities to make every patient contact count through providing health improvement advice. The NHS has set targets in relation to improvements in cancer screening coverage. CCG performance shows:

2-week from urgent GP referral to first outpatient appointment: Target 93% Actual 95.7%
One month from diagnosis to treatment: Target 96% Actual 98.5%
Two months from urgent referral to treatment: Target 85% Actual 88.0%

CCG performance against the national screening programmes standards as at 31 August 2015 shows:
Breast Screening: Target 80% Actual 70.2%
Cervical Screening: Target 80% Actual 72.7%
Bowel Screening: Target 60% Actual 54.3%

Reduction in avoidable emergency admissions
Reducing avoidable emergency admissions improves the quality of life for people with long term and acute conditions and their families, as well as reducing pressures upon the resources of local hospitals.

A 'Composite Emergency Admissions' outcome/measure was introduced in 2013/14. A low rate is an indication of a reduction in admissions that are avoidable or preventable and is viewed nationally as a measure of success. Performance as at 30 November 2015 shows:

Composite Measure: Target Rate 221.1 Actual Rate 242.8

Healthcare acquired infections
We work with partners to ensure year-on-year reductions in MRSA and Clostridium Difficile infections. CCG performance shows:

Number of MRSA: Target 0 Actual 2
Number of Clostridium Difficile: Target 38 Actual 28

Referral to treatment

National targets have been set which determine the maximum length of time patients should wait from the point at which they are referred for treatment to the time they are treated. In June 2015 the 'incomplete standard' became the sole measure of patients' constitutional right to start treatment within 18 weeks. Performance against the incomplete standard shows:

18-week referral to treatment – Incomplete: Target 92% Actual 85.7%.

Patient experience

Each year NHS England commissions a national GP patient survey to assess patients' experiences of services. Feedback received is used to inform improvements. The results of the latest survey published in January 2016 shows:

% of patients who would recommend their GP surgery to someone who has just moved to the local area: Target 77.7% Actual 73.5%

% of patients who found it easy getting through to someone at their GP surgery on the phone: Target 70.4% Actual 65.9%

% of patients with an overall positive experience of out-of-hours GP services: Target 67.0% Actual 65.1%

A&E waits

The NHS standard requires that at least 95% of patients spend 4 hours or less in any type of A&E from arrival, admission, transfer or discharge. Year to date performance as at week ending 6 March 2016 shows:

Total time in A&E: four hours or less: Target 95% Actual 74.8%

Number waiting over 12 hours: Target 0 Actual 0

Sustainability report

We are committed to achieving economic, environmental and social sustainability for our workforce and local communities through our own actions and through our commissioning. Our aims for 2014 to 2016 are to:

- Develop a sustainability policy, sustainable development management plan and implementation plan
- Determine a baseline of our resource impact and continue to monitor resource use and set stretching reduction targets
- Gain an understanding of how our building operates.

We will:

- Align our plan with the NHS Sustainability Strategy and modules
- Identify the key senior lead for sustainability, outline their responsibilities and clarify how they will report to the Governing Body
- Use the Good Corporate Citizen Tool to assess how our organisation is fairing in social, environmental and in financial terms and therefore give a measure of the sustainability of the organisation
- Utilise our workforce to develop and embed sustainable working practices
- Work with neighbouring CCGs to share learning from our sustainability programme
- Learn from developments at a national level through the Sustainable Development Unit and other NHS organisations.

Since 2014 we have been developing a sustainability plan and will carry out a joint piece of work with neighbouring CCGs, the local authority and major service providers to accelerate our progress. Together with the landlord and other occupants of our building, we will strive to develop good practice and embed it throughout the organisation.

Data and carbon footprint

In order to reduce our impact we must first understand what it is. We are working with our landlord to collect utility and resource use data including gas, electricity, waste, water, business travel and paper.

Activities to date

We are working towards achieving the objectives identified above. Since 2014, we have introduced paper shredding bins, changed all printer settings to black and white and double sided, changed the lighting system to incorporate automatic on/off settings, and worked with our energy supplier to reduce the tariff. We have promoted increased use of working from home and teleconferencing to reduce travel impact. We have raised awareness of good housekeeping such as turning off lights and computer screens.

Operating and financial review

I am pleased to report that NHS North Kirklees CCG has achieved all the financial duties set for it by the Government.

2015/16 Performance

We received two separate allocations of money from the Department of Health for 2015/16 as follows:

- Programme allocation of £238.6 million, which we used to commission health care services for the population of North Kirklees, many of which you can read about elsewhere in this Annual Report.
- Running costs allocation of £4.3 million which we used to staff and provide the support needed to commission these services.

This has been a challenging year for the CCG as we have had to work with a reduced level of financial growth and, at the same time, continue to meet the increasing needs of our population and make improvements to services for our patients.

This report summarises how we have invested this money to deliver and improve healthcare and services for North Kirklees residents. It also highlights some of the key challenges we have addressed during the year and those that face us in the coming years.

Programme allocation

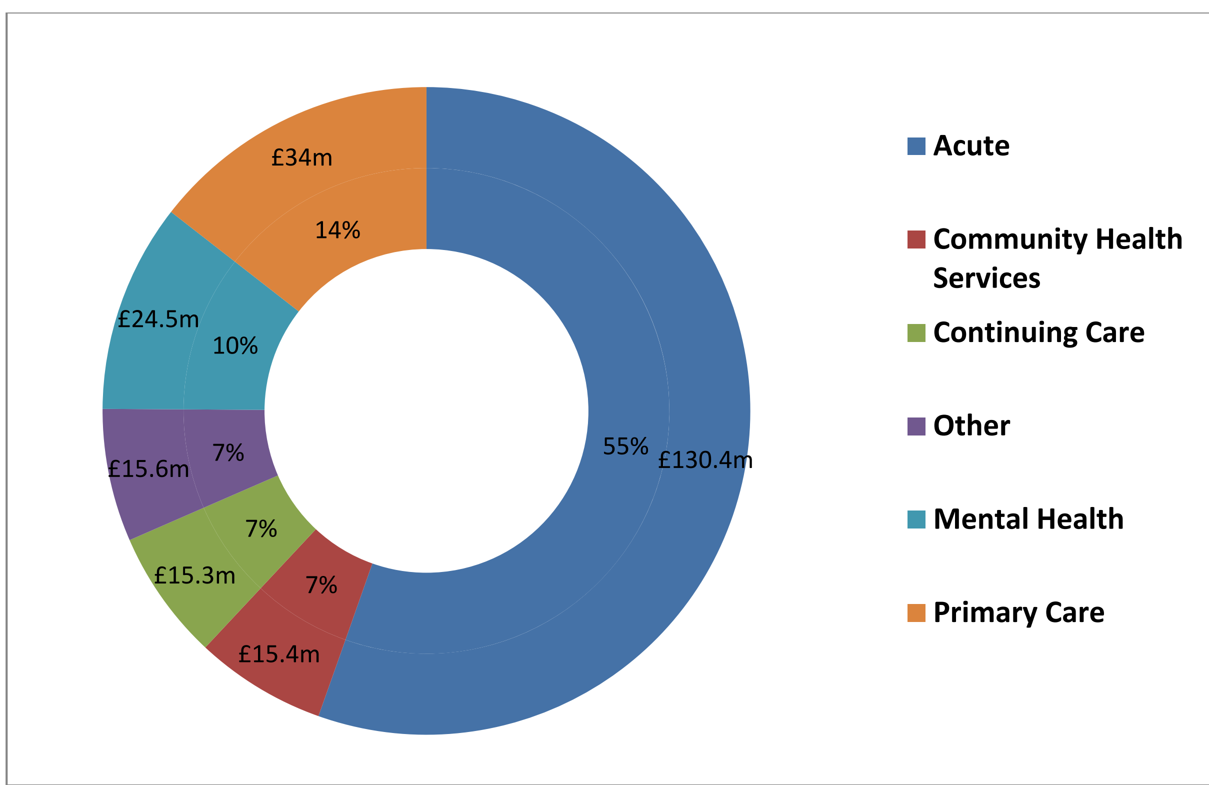
We delivered a planned surplus of £3.7 million (1.5%) against our programme allocation. This will be carried forward to support investments in services in future years.

By properly managing our finances we delivered £8.1 million of our planned efficiency programme of £10 million. We did this by putting community services in place to support people to be cared for at home and therefore reducing unnecessary hospital admissions and stays, improving the cost effectiveness of continuing care packages, and by improving the efficiency and appropriateness of primary care prescribing.

We spend our money with a range of organisations. These include NHS and non-NHS hospitals, community organisations, GPs (including prescription costs), and a range of providers of continuing healthcare.

During the year, we instigated our strategy for caring for people at or closer to home. To support this we prioritised our investments into services which supported this strategy. We have invested £11.8 million in Better Care Fund programmes, which are designed to deliver a higher quality of care in the community and reduce the pressure on hospital admissions and A&E departments.

The diagram below provides a summary of how we spent your money.



Running costs allocation

The CCG is provided with a running costs allocation which allows us to employ staff and pay for commissioning support services. Our spend on running costs amounts to £25 per year for each member our population. We are not allowed to spend more than this allocation and we achieved

this. This has been a challenge and we have done so working jointly with other CCGs, the local authority and our provider of commissioning support services. We have tried to focus on those things which help us to make the biggest improvements to the health services available to the people of North Kirklees. Information on levels of staff sickness is provided in the financial statements.

Looking forward

Along with the rest of the public sector, we face a financially challenging position going forward. We have received an increase of just over 2.5% in our programme allocation for 2016/17 and are required to provide more services for patients to meet demographic changes within these constrained financial resources. This represents a significant challenge, but we are well placed to achieve our goal, by amongst other things, continuing to work closely with neighbouring CCGs, NHS providers of services and our local authority.

We continue to work closely with partner organisations, and in particular the local authority and NHS Greater Huddersfield CCG, to identify more effective ways of delivering health and social care across the whole of Kirklees. The establishment of the Better Care Fund to begin to pool resources across Kirklees in 2015/16 is one way in which we are doing this. We have a signed agreement in place across Kirklees setting out how we will do this during 2016/17. We continue to work with the local authority to develop and deliver our linked strategies to improve health and wellbeing and economic development and sustainability.

Primary care co-commissioning is one of a series of changes set out in the NHS Five Year Forward View. Co-commissioning allows CCGs to take on greater responsibility for primary care services in their local area. There are three levels of co-commissioning. NHS North Kirklees CCG is currently working at a level to ensure greater involvement in primary care decision making. Whilst the CCG remains at this level, the financial effect on the CCG is expected to be negligible. However, we are conducting an overall commercial review of all our activities to ensure that we are fully represented and engaged in all primary care decision making.

Better payments practice code

The Better Payments Practice Code requires the CCG to aim to pay all valid invoices by the date due or within 30 days of receipt of a valid invoice, whichever is the later. The NHS aims to pay 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the

code are given within the notes to the financial statements. We have signed up to the Prompt Payment Code.

Financial probity

We take our responsibilities for safeguarding public money and achieving value for money very seriously. On behalf of the Governing Body, our external auditors considered financial governance. The members of the Audit Committee received regular reports from our external auditors, and from our internal auditors. Our expenditure on external audit is included in the financial statements.

Annual financial statements

Our annual financial statements are included in this report. These provide more detail on how we have spent our resources in 2015/16.

Signed on behalf of
Chris Dowse
Chief Officer
25 May 2016

ACCOUNTABILITY REPORT

Corporate governance report

Members' report

Member practices forming the membership body of the CCG are listed below:

PRACTICE NAME	PRACTICE MANAGER	GP LEAD
Albion House	Anne Wade	Adnan Jabbar
Dr Mahmood & Partners	Mohammed Zahoor	Yasar Mahmood
The New Brewery Lane Surgery	Gillian Lawson	Yunus Asmal
Wellington House	Roy Partington	Stuart Lawson
Savile Town Medical Centre	Taveed Jan	Haffizullah Bhat
North Road Suite	Elaine Oldroyd, Lynne Bolton	Natarajan Chandra
Greenside Surgery	Emma Marshall	Victor D'Ambrogio
Blackburn Road Medical Centre	Jan Randall	David Fowers
Healds Road Surgery	Robina Naz	Nasar Khan
Broughton House Surgery	Helen Jones	Jill Gogna
Batley Health Centre	Janey Hellings	Syed Hassan
Eightlands Surgery	Natasha Brown	Muhammad Dadibhai
Kirkgate Surgery	Joanne Parker	Shanza Bila
Liversedge Health Centre	Robina Naz	Nasar Khan
Mirfield Health Centre	Joanne Swords	Mohammed Hussain
Undercliffe Surgery	Andrea MacKay	Antony Goodwin Mohammed Hussain
Grove House Surgery	Diane Fox	Maura Lynch
Drs Medley, Conway & Spencer	Clare Townend	Heather Spencer

PRACTICE NAME	PRACTICE MANAGER	GP LEAD
Windsor Medical Centre	Sylvia Brown	Ajit Mehrotra
St John's House	Jayne Crorken	Sarah Nicholls
Thornhill Lees Medical Centre	Susan Andrews	Yakub Patel
Mount Pleasant Medical Centre	Lynn Batley	Zubair Dalal Mohammad Khan
The Paddock Surgery	Karen Frank	Christopher Robinson
The Greenway Medical Practice	Angie Dickinson	Belinda Scrivings
Cherry Tree Surgery	Margaret Brook	Rajinder Sood
Parkview Surgery	Carol Eastwood	Yasar Mahmood
Albion Mount Medical Practice	Karen Goodfellow	Hanume Thimmegowda
Brookroyd Surgery	Julie Jones	Nigel Myers
Victoria Medical Practice	Louise Gregory	Jeremy Sager

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Governing body and register of interests

NAME	POSITION	INTEREST
Chris Dowse	Chief Officer (Until 31 March 2016)	• No interests to declare
David Kelly	Chair	• Partner, Brookroyd Surgery • GP Director, Heckmondwike Health Centre Pharmacy • Practice is member of and has a share in Curo Health Limited • Wife is a shareholder in Floor Target and a nurse at Bradford Royal Infirmary
Pat Keane	Interim Chief Operating Officer (From February 2016)	• No interests to declare
Steve Brennan	Chief Finance Officer	• No interests to declare
Deborah Turner	Head of Quality and Safety and Chief Nurse	• No interests to declare
Rachael Kilburn	Governing Body Member	• Partner, Parkview Surgery and Dr Mahmood & Partners • Practices are members of and have a share in Curo Health Limited
Andrew Cameron	Governing Body Member	• Partner, Greenway Medical Practice • Practice is member of and has a share in Curo Health Limited • Practice is sole provider of medical services to Hollybank Trust residential home • Wife is partner at Grange Group Practice in Huddersfield, which is a member of Huddersfield Prime Health Federation.
Yasar Mahmood	Governing Body Member	• Partner, Parkview Surgery and Dr Mahmood & Partners • Practices are members of and have a share in Curo Health Limited
Kathryn Greaves	Governing Body Member	• Practice is member of and has a share in Curo Health Limited • Occasional practice tutor, Leeds Metropolitan and Leeds universities • Husband employed by The Charity Service, which is responsible for administering third sector grants on behalf of several CCGs
Khalid Naeem	Governing Body Member	• Partner, Mount Pleasant Medical Centre • Practice is member of and has a share in Curo Health Limited • Director, Mount Pleasant Pharmacy, Dewsbury • Personal injury claims medical legal expert • Parent Governor, Heckmondwike Grammar School • Wife employed by Batley Girls High School Visual Arts College
Nadeem Ghafoor	Governing Body Member	• GP, Liversedge Health Centre, Healds Road Surgery • Practice is member of and has a share in Curo Health Limited

NAME	POSITION	INTEREST
Tony Gerrard	Lay Member (Until 31 October 2015)	• Lay member, NHS Greater Huddersfield CCG • Director, Tony Gerrard Associates Ltd
Adnan Jabbar	Governing Body Member	• Partner, Albion Street Surgery • Partner, Cherry Tree Surgery • Practice is member of and has a share in Curo Health Limited
Kiran Bali	Lay Member	• No interests to declare
Joanne Crewe	Nurse Representative	• Operational Director, Harrogate and District NHS Foundation Trust
Matt Shepherd	Secondary Care Consultant (Until 31 March 2016)	• Employee, Harrogate and District NHS Foundation Trust
Julie Elliott	Lay Member	• Director, Julie Elliott Ltd • Lecturer, Huddersfield University
Colin Meredith	Lay Member (From 1 November 2015)	• Director, Utley General Services Ltd • Employee, Rastrick High School Academy Trust
IN ATTENDANCE		
Rachel Spencer-Henshall	Director of Public Health, Kirklees Council	• No interests to declare
Richard Parry	Director of Commissioning, Public Health and Adult Social Care, Kirklees Council	• No interests to declare

Audit committee

The Audit Committee has delegated responsibility from the Governing Body to oversee the CCG's governance, risk management and internal control processes. The committee works closely with internal and external audit. Below are details of the members of the Audit Committee during the year and up to the signing of the Annual Report and Accounts.

NAME	POSITION
Tony Gerrard	Lay Member, Chair (Until October 2015)
Colin Meredith	Lay Member, Chair (From 1 November 2015)
Julie Elliott	Lay Member, Vice Chair
Andrew Cameron	Governing Body Member
Rachael Kilburn	Governing Body Member
IN ATTENDANCE	
Steve Brennan	Chief Finance Officer

NAME	POSITION
David Fox	Interim Chief Finance Officer (From January until March 2016)
Nigel Bell	Head of Internal Audit, West Yorkshire Audit Consortium (Until October 2015)
Michelle Marsden Helen Kemp Taylor	Internal Audit Manager, West Yorkshire Audit Consortium (Until June 2015) Acting Head of Internal Audit (From October 2015)
Leanne Sobratee	Internal Audit Manager, West Yorkshire Audit Consortium (From August 2015)
Tim Cutler	External Audit Representative , KPMG
Simon Dennis	External Audit Representative, KPMG (Until November 2015)
James Boyle	External Audit Representative, KPMG (From December 2016)
Pat Patrice	Governance, Corporate Affairs and Senior Manager
Steve Nicholls	Local Counter-Fraud Specialist

Personal data related incidents

There were no incidents requiring a report to or an investigation by external bodies such as the Information Governance Commissioner or the Health and Safety Executive.

Statement as to disclosure to auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and
- He/she has taken all the steps that they ought to have taken as a member in order to make himself/herself aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Statement of accountable officer's responsibilities

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

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my clinical commissioning group Accountable Officer Appointment Letter.

Governance statement

Introduction and context

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2014, the clinical commissioning group was licensed without conditions.

Scope of responsibility

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

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

Compliance with the UK corporate governance code

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

The CCG commissioned an external governance review which was carried out by the Capsticks Governance Consultancy Service between December 2014 and February 2015. The review acknowledged that there were "many strong elements of corporate governance in place within NHS North Kirklees Clinical Commissioning Group" along with other numerous areas of good practice. To further strengthen corporate governance the review highlighted some areas for development and improvement, including the streamlining of some processes to create greater time and space for clinically driven strategic discussions by the Governing Body, and which would draw in the wider CCG

membership base. An implementation plan has now been developed to carry forward recommendations made by the review.

Governance framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states: “The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.”

Our constitution sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for the people for whom it is responsible. It describes the governing principles, rules and procedures that the CCG will establish to ensure probity and accountability in the day to day running of the CCG, to ensure that decisions are taken in an open and transparent way, and that the interests of the patients and the public remain central to the goals of the CCG. The constitution includes:

- Membership
- The area we cover
- Arrangements for the discharge of our function and those of our Governing Body
- The decision making process
- Arrangements for discharging our duties in relation to register of interests and managing conflicts of interest
- The CCG as an employer.

The governing body and committee structure

The constitution sets out the duties, responsibilities and overall framework for the good governance of the CCG. The constitution, approved by NHS England in January 2015, sets out the structures, systems and process for the discharging of duties, delivery of responsibilities and arrangements for decision-making.

The Governing Body comprises a clinical leader who is the Chair, five GP members, a chief nurse, a practice nurse, chief finance officer, a secondary care consultant member, three lay members including one with specific responsibility for governance, audit and risk as well as one with specific responsibilities for patient and public involvement.

As Accountable Officer, I am also a member of the Governing Body. The lay members, together with the secondary care clinician have important roles within the governance framework of the CCG. The Governing Body has an ongoing role in reviewing the CCG's governance arrangements to ensure that these continue to reflect the principles of good governance. The Governance and Corporate Affairs and Audit Committees play a role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

During the year 2015/16, the CCG's Governing Body met on seven occasions. All meetings were held in public and agendas were structured to deal with strategic, performance, quality assurance, risk and governance issues. The Governing Body has established three principal committees for the conduct of its business. Each committee is chaired by a member of the Governing Body and all have important roles in the governance framework.

Audit committee

The Audit Committee has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and financial reporting. The committee is authorised to seek any information it requires from any employee. All employees are directed to cooperate with any such request made by the committee. The Audit Committee met on seven occasions over the period of this report and highlights are as follows. The committee:

- Has undertaken an annual review of its performance
- Reviewed the Prime Financial Policies throughout the year (NB these policies have replaced the previously used Standing Orders, Scheme of Delegation and Standing Financial Instructions)
- Reviewed the internal and external audit progress reports
- Reviewed the final accounts (2014/15)
- Reviewed the timetables and plans, losses and compensations on a quarterly basis
- Reviewed the Governing Body Assurance Framework
- Reviewed the high level risks on the Risk Register
- Reviewed the Risk Management Framework
- Reviewed the information governance updates
- Reviewed the emergency preparedness resilience and response (including the system resilience updates)

- Reviewed the equality and diversity updates.
- Reviewed the terms of reference, the work plan and the annual report

Terms and remuneration committee

The Terms and Remuneration Committee has delegated responsibility from the Governing Body for advising on all aspects of salary not covered by Agenda for Change, arrangements for termination of employment, monitoring and evaluating the performance of individual Governing Body members, and approving contracts for staff. The committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the committee. The committee is authorised by the Governing Body to obtain outside legal or other relevant experience and expertise if it considers this necessary. The Terms and Remuneration Committee met on four occasions and highlights are as follows, the committee:

- Reviewed remuneration terms and conditions for all posts not subject to Agenda for Change
- Undertook an annual review of its performance
- Reviewed the process for Governing Body member succession planning
- Reviewed contractual status of Governing Body members
- Reviewed the recruitment timeline for Governing Body members whose tenures were due to expire
- Reviewed the process for engaging clinical advisors to the care closer to home programme
- Reviewed the co-opted members' policy
- Reviewed the recruitment and retention premium
- Reviewed the terms of reference, the work plan and annual report
- Reviewed the very senior managers pay
- Reviewed the Memorandum of Understanding for joint appointments.

Refer to page 48 for membership and other details.

Quality, performance and finance committee

The Quality, Performance and Finance Committee has delegated responsibility from the Governing Body for securing continuous improvement in the quality of services commissioned and ensuring patient experience, clinical effectiveness and patient safety (including safeguarding) is stratified to

support commissioning decisions. The committee met on 16 occasions and highlights are as follows. The committee:

- Identified and reported appropriate risks relating to quality, clinical effectiveness, patient safety, safeguarding and patient experience as described in the terms of reference
- Received and reviewed reports and subsequent action plans from providers in relation to internal and external scrutiny including the Care Quality Commission and National Patient Safety Agency
- Oversaw delivery of the CCG's quality, financial and commissioning strategies including approval of business cases within the scheme of delegation.
- Agreed key performance indicators regarding achievement of financial targets and ensured effective monitoring
- Reviewed the terms of reference, the work plan and the annual report.
- Reviewed quality and safety.
- Reviewed finance and contracting.
- Reviewed the performance reports and escalated concerns where appropriate.
- Reviewed the governance, strategy and operational planning.

Governance and corporate affairs committee

The Governance and Corporate Affairs Committee has delegated responsibility from the Governing Body for the CCG's public sector equality duties, public and patient involvement, compliance with the NHS Constitution, patient experience, engagement and strategic planning. The committee met on one occasion during 2015/16 and was disbanded in July 2015. The committee reviewed the work plan and established governance arrangements for all the items within its remit.

Risk management framework

The Integrated Risk Management Framework was updated and revised during the year to ensure that it accurately describes the CCG's approach to managing its risks. The revised framework was reviewed by the Governance and Corporate Affairs Committee in July 2015.

NHS North Kirklees CCG is committed to the active management of risk within the services it commissions. It has done this during 2015/16 by continuing to develop and maintain a positive risk management culture throughout the organisation. It has sought to minimise risks wherever possible

both internally and to service users, the public, staff, members and other stakeholders as far as reasonably practicable, and in accordance with current guidance, legislation and best practice. Specifically, the CCG's Integrated Risk Management Framework describes:

- The CCG's approach to identifying and managing risks
- The CCG's risk management processes
- The CCG's strategic priorities
- The Risk Management Statement
- The CCG's risk management objectives
- The CCG's risk appetite
- A clear accountability framework for the management and reporting of risk at both individual and organisational level.

The Accountable Officer and Chief Finance Officer have been actively involved in the development of the assurance framework and risk register management during the year. Individual CCG staff were equipped to manage risk in the following ways during the year:

- A series of one-to-one sessions on managing the corporate risk register were held with risk owners, senior managers and directors.
- A series of individual meetings to identify strategic risks for the assurance framework were held with heads of service, Chair and Chief Officer.
- CCG staff underwent health and safety training.

When untoward events occur, the incident reporting system is configured to direct a notification to the reporter's line manager, who has a responsibility to investigate and sign off the incident and identify any learning opportunities.

The incidents reported during the year range from staff accidents to information governance issues and building security.

Identification of risk

The CCG has identified risks during the year as described in the Integrated Risk Management Framework. Triangulation of soft and hard information from different sources gives assurance that

all significant risks have been captured. The key sources of information used to check completeness of risk capture are:

- Performance indicators reporting variance from plan within commissioning performance contracts and their reports
- The results of planned reviews of compliance with statutory and regulatory requirements e.g. fire regulations, Care Quality Commission standards and reviews, Ofsted reviews, Parliamentary Ombudsmen, professional standards, information governance systems including Information Governance Toolkit
- Routine review of serious incidents, incident reports and complaints to identify emerging risks such as themes or specific concerns which can be escalated to the appropriate risk registers.
- Utilisation of intelligence through partner networks and from stakeholders to encourage the sharing of information to identify potential risks
- Ensuring contact with regional and national professional associations that provide early warning on serious or major adverse events
- Risk review and discussion through operational groups and formal meetings, i.e. Governing Body, Audit Committee, Governance and Corporate Affairs Committee, Quality, Performance and Finance Committee and Clinical Strategy Group which highlight problems and issues which should be reflected in the corporate risk register

Risk assessment

The risk assessment process is mapped to our strategic objectives. The CCG has used a structured approach to risk assessment during the year to:

- Identify risks
- Understand their potential impact
- Examine what control measures can be applied and their effectiveness
- Decide if further actions are necessary other than control measures
- Score risks and categorise the potential of any outstanding risk after the above processes.

Evaluation of risk

Risk evaluation is a robust process governed by the framework and is carried out by the risk owner and reviewed by a relevant senior manager, Audit Committee and Governing Body in accordance with the relevance and severity of the risk. Each risk was:

- Analysed to understand its potential impact
- Examined in relation to existing control measure and consideration was given to their application and effectiveness
- Evaluated to decide if further actions are necessary other than control measures
- Scored in line with a 5 x 5 matrix to categorise the potential of any outstanding risk after the above processes.

Operational or corporate risks were detailed in the corporate risk register and risks to the strategic aims of the CCG were recorded in the assurance framework.

Risk prioritisation

Each risk was given a risk score which determined the prioritisation and allocation of resource. Higher scores have a higher priority for action as the impact of failing to reduce the risk is greater. Each risk had an agreed target score to indicate the level at which the risk is acceptable to the CCG. The target score was reviewed as part of each review cycle and four risk review cycles took place during 2015/16.

Risk management

The organisation has effective processes to capture and learn from mistakes to reduce future risks, including review of risks marked for closure on the risk register, conducting root cause analysis on reported incidents, triangulating intelligence from complaints, incidents and claims and collating information from external organisations such as Audit Commission, NHS England and the Parliamentary and Health Service Ombudsman. During the year risks were mitigated in the following ways:

- Financial risks were mitigated through strict internal controls contained in Standing Orders, Standing Financial Instructions and the Scheme of Delegation (subsequently replaced by the Prime Financial Policies). Internal and external audit provided independent assurance on minimising the impact of risk.
- Health and safety risks were prevented through regular risk assessment and by demonstrating learning from incidents and complaints.

Risk management has been embedded into the CCG over the last year through:

- Bespoke risk management, health and safety and incident reporting support
- A comprehensive web-based risk register system covering every function of the CCG
- Web-based incident reporting system which requires reported risks to be reviewed and signed off by a senior member of staff
- Demonstrating the risk register live at the senior management team meetings
- Working with heads of service to effectively articulate risks and controls
- A range of policies including; risk management, the management of serious incidents, health and safety, complaints, whistle blowing
- Integration of equality impact assessments into business planning processes.

The final risk register considered in 2015/16 included the following highest scoring risks:

PRINCIPLE RISK	KEY CONTROLS
Risk that the CCG will fail to deliver its financial duties in 2015/16.	Monitor expenditure, QIPP delivery. Identification and delivery of mitigating actions. Monthly monitoring at Quality, Performance and Finance Committee.
Risk of being unable to source appropriate nursing home beds resulting in patients being placed out of area.	CCG working with the local authority, providers and residents to ensure those transferred to new places remain safe and well.
Risk that the system resilience for unplanned care will not deliver anticipated performance of the 95% A&E standard due to a lack of resources to meet the additional surge in activity.	Mitigated by the establishment of System Resilience Group for the Mid Yorkshire area.
Risk that the needs of child and adolescent mental health service users will not be met in terms of access and patient experience.	Revised recovery plan in place, which is monitored through contract management group Monthly reports to the Quality, Performance and Finance Committee.
Risk that CCG will not receive the necessary commissioning support due to the transition and closure of support unit.	Regular meeting of Yorkshire and Humber Transition Board. Action plans in place.
Risk that Mid Yorkshire Hospitals NHS Trust will not achieve 18 weeks referral to treatment target, affecting the CCG's quality premium payment.	Formal monitoring by Contracting Board.
Risk of failing to deliver QIPP requirement.	Plan in place. Monthly monitoring by Quality, Performance and Finance Committee.

PRINCIPLE RISK	KEY CONTROLS
Risk that expenditure exceeds budget.	Contract management in place. Monthly monitoring by Quality, Performance and Finance Committee. Bi-monthly monitoring by Governing Body.
There is a risk that patients may not receive optimum care at Mid Yorkshire Hospitals NHS Trust.	Trust has a remedial action plan which has been submitted to Care Quality Commission and approved by the Trust Development Authority.

Internal control framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

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

The Integrated Risk Management Framework establishes the risk and control framework for the CCG. The framework links supporting and associated policies. The framework comprises five key elements:

1. The organisation has appropriate and effective systems in place to identify, report and manage risks.
2. The organisation has effective processes to capture and learn from mistakes to reduce future risks, including review of closed risks on the risk register, conducting root cause analysis on reported incidents, triangulating intelligence from complaints, incidents and claims and collating information from external organisations.
3. An effective accountability framework for the management and reporting of risk is in place, separating the CCG's internal governance arrangements for risk processes and management of risk, and accountability to NHS England for the operational management of risk.
4. The organisational risk management framework provides sufficient evidence and assurance to comply with relevant external assessment and best practice.
5. The CCG has developed risk management arrangements for key partnerships and major projects.

Information governance

The CCG has appointed a Senior Information Responsible Officer (SIRO), Caldicott Guardian and an information governance (IG) lead.

Information governance compliance is managed and controlled through the implementation of the organisation's IG Framework and annual IG Improvement Plan which includes a programme of work around information asset risk management.

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 framework is supported by an IG Toolkit and the annual submission process provides assurances to the CCG, other organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust IG systems and processes in place to help protect patient and corporate information. We have established an IG management framework and developed IG processes and procedures in line with the IG Toolkit. In relation to the requirements of IG Toolkit (version 12), the CCG has achieved a score of Level 2 in its assessment with an overall grade of 'satisfactory'.

We have ensured all staff undertake annual IG training and have implemented a staff information governance handbook to ensure staff are aware of their roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

Risk assessment in relation to governance, risk management and internal control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the CCG. My review is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development

and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle objectives have been reviewed.

I am pleased to see the full/significant opinion given on the design and governance and gaps. The assurances section is one that is commonly identified as a weakness in Board Assurance Frameworks. The Board Assurance Framework was approved by our Governing Body in April 2015.

Review of economy, efficiency and effectiveness of the use of resources

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

The Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance. The Chief Finance Officer has delegated responsibility to determine arrangements to ensure a sound system of financial control. The Governing Body receives regular reports summarising the financial performance of the CCG. In addition, the Quality, Performance and Finance Committee and the Audit Committee have important roles to play in assuring the Governing Body on the arrangements in place to secure economic, efficient, and effective use of resources by:

- The Quality Performance and Finance Committee receives and scrutinises regular detailed reports on the financial performance of the CCG, including updates on the delivery of our quality, innovation, productivity and prevention plans (QIPP).
- The Audit Committee also receives a regular update from the Chief Finance Officer on the financial position of the CCG. It also receives and reviews the work and opinions of our internal and external auditors.

Accounts scrutiny and sign-off is via the Audit Committee under delegated authority from the Governing Body, with the accounts having first been reviewed in detail at its meeting in May. Systems of financial control have been reviewed by internal audit, which resulted in an outcome of significant assurance.

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

The delegation chain is documented within the scheme of delegation which is included within the CCG constitution. The constitution can be found on the CCG website. The review of the accounting policies and the scheme of delegation is included within the audit work plan.

Capacity to handle risk

Within the Risk Management Framework section of this document I have set out the ways in which leadership is given to the risk management process within the CCG.

All risk owners, senior reviewers and heads of service, are trained and equipped to manage risk in a way that is appropriate to their authority and duties. The CCG's Integrated Risk Management Framework clearly sets out the duties and responsibilities of risk owners and senior reviewers. We are supported in the management of risks by NHS Yorkshire and Humber Commissioning Support Service. They provide expert advice on the use of the risk management system, identify good practice from elsewhere and provide guidance to staff on the identification of risks and associated controls and assurances.

During 2015/16, all risk owners and senior reviewers have received additional support to review each of their risks with an expert from the commissioning support governance and risk team to ensure that risks are correctly identified, accurately reported, scored and managed, and regularly reviewed.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG 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.

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed.

We will continue to work with Internal Audit to refresh, improve and strengthen the Governing Body Assurance Framework, and if appropriate a plan to address areas of development and ensure continuous improvement of the system is in place.

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.

Head of internal audit opinion on the effectiveness of the system of internal control at NHS North Kirklees Clinical Commissioning Group for the year ended 31 March 2016

Roles and responsibilities

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

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

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

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

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

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

The head of internal audit opinion

The purpose of my annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accountable Officer, the CCG 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

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

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

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

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

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

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

During 2015/16 the CCG's arrangements for managing risk and providing assurance to the Governing Body have continued to mature.

The Governing Body has identified its objectives, risks, controls, sources of assurance and gaps in control/assurance and has created and agreed an Assurance Framework. A review of the design and operation of the Assurance Framework and associated processes was completed and I can conclude that the methodology surrounding the design and operation of the framework has been sound.

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

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

- Governance (incorporating assurance and risk management)
- Securing improvements in quality
- Commissioning and contract management
- Business development
- Integration
- Financial governance
- Information governance

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

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

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

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

An advisory audit was completed in November 2015 in relation to the Assurance Framework; however, a follow up audit has since been completed and an assurance opinion provided. Two other advisory audits have been undertaken during 2015/16. These were in relation to a Risk Register Benchmarking exercise and a survey on lead and collaborative commissioning.

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

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

Audit	Assurance Level
Assurance Framework (Part 1)	No opinion
Assurance Framework (Part 2)	Significant
Conflict of Interest	Significant
Financial Control Environment Checklist	Significant
Care in Care Homes	No opinion
Better Care Fund	Significant
Francis Report	Significant
Financial Transactions	Significant
Information Governance Toolkit	No opinion
Contract Management	Significant
Quality Improvement	Significant
Quality, Innovation, Productivity and Prevention (QIPP)	Limited

Taking into account the internal audit work completed, all of my findings and the CCG's actions to date in response to my recommendations to date, I believe the following areas of significant risk remain:

QIPP – The audit identified a number of weaknesses which mainly relate to the processes in place for the monitoring, management and reporting of individual QIPP schemes which form part of the CCG's overall QIPP plan. It is noted that the CCG's focus on QIPP has shifted significantly since initial audit work was carried out with there now being an increased focus on both accountability and deliverability of QIPP. A detailed action plan has been agreed with the responsible officers at the CCG. Work has commenced on addressing the issues but as at 31 March 2016 these actions were not complete. Consequently, until fully addressed these risks remain.

Looking ahead

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

Following the retirement of the Chief Officer at the end of 2015/16 a new Chief Officer has been appointed for an initial 12 month period while the CCG seeks to make a permanent appointment. It is possible that the CCG may take the opportunity to review and refresh its objectives, risks and controls in the coming months.

Looking ahead to 2016/17 the CCG has submitted a financial plan that does meet the business rules set by NHS England, that is, to deliver the a minimum 1% surplus. In 2016/17, the CCG has agreed a QIPP target of £9.8 million with NHS England but has internally set itself an overall QIPP target of £13.2 million. NHS England is fully supportive of the CCG having a more challenging internal budget compared to the financial plan submitted to them.

Helen Kemp Taylor
Acting Head of Audit
April 2016

Data quality

The quality of data presented to the committees and the Governing Body continues to evolve. The committee checklist is completed after every Governing Body or committee meeting as part of the annual assessment process, and the information provided from this shows that the majority of the Governing Body members confirm that they receive clear and concise information enabling them to make a decision or receive assurance on a matter.

Further work around the production of papers, the completion of the front sheets and meeting deadlines are all areas that the governance team within the CCG are now reviewing. This is monitored and reviewed after every meeting and in agenda setting meetings.

The CCG requires that reports which are submitted to the committees and Governing Body clearly set out the detail required and that a good quality of data is provided across a range of areas within finance, contracting, performance, quality and patient experience.

Business critical models

In the Macpherson report, *Review of Quality Assurance of Government Analytical Models*, published March 2013, it was recommended that the Governance Statement should include confirmation that an appropriate Quality Assurance Framework is in place and is used for all business critical

models. Business critical models were deemed to be analytical models that informed government policy. The CCG has not developed any analytical models which have informed government policy.

Data security

We have submitted a satisfactory level of compliance with the Information Governance Toolkit assessment. We have had no serious untoward incidents relating to data security breaches.

Discharge of statutory functions

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

In light of the Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislation and regulations. As a result, I can confirm that NHS North Kirklees 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 a head of service. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Conclusion

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

Signed on behalf of
Chris Dowse
Chief Officer
25 May 2016

Remuneration and staff report

The Government Financial Reporting Manual requires that a remuneration report shall be prepared containing information about the remuneration of senior managers. In the NHS, the report will cover, "Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the clinical commissioning group. This means those who influence the decisions of the clinical commissioning group as a whole rather than the decisions of individual directorates or departments". We have determined that for our CCG, the definition of senior managers for the purposes of this remuneration report means members of the Governing Body.

Terms and remuneration committee report

The Terms and Remuneration Committee has delegated responsibility from the Governing Body for advising on all aspects of salary not covered by Agenda for Change, arrangements for termination of employment of individual Governing Body members and approving contracts for all Governing Body members.

The committee is authorised by the Governing Body to investigate any activity within its terms of reference. It may seek any information it requires from any employee and all employees are directed to co-operate with any request made by the committee. The committee is authorised by the Governing Body to obtain outside legal or other relevant experience and expertise if it considers this necessary.

NAME	POSITION
Kiran Bali	Lay member, Chair
Tony Gerrard	Lay member, Vice Chair (Until 31 October 2015)
Colin Meredith	Lay member, Vice Chair (From 1 November 2015)
Julie Elliott	Lay member
Khalid Naeem	Governing Body Member

The committee received human resource advice from NHS Yorkshire and Humber Commissioning Support until February 2016. The service transferred to Calderdale and Huddersfield NHS Foundation Trust on 1 March 2016. Financial advice is provided by the CCG Chief Finance Officer. The committee met five times this year and attendance records show it has been quorate at each meeting.

Policy on remuneration of senior managers

The Terms and Remuneration Committee established the levels of remuneration for Governing Body senior managers taking into account the Hutton review on Fair Pay in the Public Sector and NHS Commissioning Board Guidance at the time for determining appropriate remuneration levels for members of the Governing Body. The committee made appropriate use of relevant public sector comparative information and also acknowledged that this would be kept under review on an ongoing basis.

Senior managers' performance related pay

The senior managers of the CCG do not receive performance related pay in addition to their contracted levels of remuneration.

Policy on senior managers' contracts

The table below provides details of the service contract for each senior manager who has served during the year. The contracts do not make any specific provisions for compensation for early termination in addition to the notice periods.

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NAME AND TITLE	CONTRACT DATE	UNEXPIRED TERM	NOTICE PERIOD
David Kelly* Chair	01.12.12	Ends 31.10.18	3 Months
Chris Dowse Chief Officer	01.04.13	Ended 31.03.16	3 Months
Steven Brennan Chief Finance Officer	01.04.13	No end date	3 Months
Deborah Turner Head of Quality and Safety and Chief Nurse	01.04.13	No end date	3 Months
Nadeem Ghafoor* Governing Body Member	01.12.12	Ends 31.10.18	3 Months
Yasar Mahmood* Governing Body Member	01.12.12	Ends 31.10.18	3 Months
Khaled Naeem Governing Body Member	01.07.13	Ends 30.06.16	3 Months
Kathryn Greaves Governing Body Member	01.07.13	Ends 30.06.16	3 Months
Rachael Kilburn* Governing Body Member	01.12.12	Ends 31.10.18	3 Months
Matthew Shepherd (resigned with effect from 31.03.16) Secondary Care Clinician	07.05.14	Ends 06.05.17	3 Months
Joanne Crewe* Secondary Care Nurse	01.11.12	Ends 31.10.18	3 Months
Tony Gerrard Lay Member	01.11.12	Ended 31.10.15	3 Months
Julie Elliott* Lay Member	30.01.13	Ends 28.01.19	3 Months
Kiran Bali Lay Member	29.05.13	Ends 28.05.16	3 Months
Andrew Cameron Governing Body Member	02.10.13	Ends 31.05.17	3 Months
Adnan Jabbar Governing Body Member	01.01.14	Ends 31.05.17	3 Months
Colin Meredith Lay Member	01.11.15	Ends 31.10.18	3 Months

Note: Contract date reflects the date of appointment to the shadow CCG during 2012/13 where appropriate.

*Individual has had two terms of office and will not be eligible for a further term.

Payments to past senior managers

We have not made any awards to past senior managers in addition to the remuneration disclosed later in this report.

Salaries and allowances

The table below shows the salaries and allowances for 2015/16 compared to 2014/15 for all senior managers who have served during the 2015/16 financial year.

	2015/16						2014/15					
Name and title	Salary bands of £5,000	Expense payments (taxable) rounded to nearest £100	Performance pay and bonuses bands of £5,000	Long term performance pay and bonuses bands of £5,000	All pension related benefits bands of £2,500	TOTAL bands of £5,000	Salary bands of £5,000	Expense payments (taxable) rounded to nearest £100	Performance pay and bonuses bands of £5,000	Long term performance pay and bonuses bands of £5,000	All pension related benefits bands of £2,500	TOTAL bands of £5,000
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
David Kelly Chair	110-115				12.5-15	125-130	110-115	0	0	0	10-12.5	125-130
Chris Dowse (Until 31.03.16) Chief Officer	115-120				22.5-25	140-145	115-120	0	0	0	20-22.5	135-140
Steven Brennan Chief Finance Officer	90-95				12.5-15	105-110	90-95	2100	0	0	5-7.5	100-105
Deborah Turner Head of Quality and Safety & Chief Nurse	60-65				7.5-10	70-75	10-15	0	0	0	2.5-5	10-15
Nadeem Ghafoor Governing Body Member	65-70					65-70	65-70	0	0	0	0	65-70
Yasar Mahmood Governing Body Member	50-55					50-55	50-55	0	0	0	0	50-55
Khaled Naeem Governing Body Member	30-35					30-35	35-40	0	0	0	0	35-40
Kathryn Greaves Governing Body Member	10-15					10-15	10-15	0	0	0	0	10-15
Rachael Kilburn Governing Body Member	25-30					25-30	25-30	0	0	0	0	25-30
Matt Shepherd (Until 31.03.16) Secondary Care Clinician	5-10					5-10	5-10	0	0	0	0	5-10

	2015/16						2014/15					
Joanne Crewe Nurse Representative	5-10					5-10	5-10	0	0	0	0	5-10
Tony Gerrard (Until 31.10.15) Lay Member	5-10					5-10	10-15	0	0	0	0	10-15
Julie Elliott Lay Member	10-15					10-15	10-15	0	0	0	0	10-15
Kiran Bali Lay Member	5-10					5-10	5-10	0	0	0	0	5-10
Andrew Cameron Governing Body Member	50-55					50-55	45-50	0	0	0	0	45-50
Adnan Jabbar Governing Body Member	50-55					50-55	45-50	0	0	0	0	45-50
Colin Meredith (From 01.11.15) Lay Member	0-5					0-5	0	0	0	0	0	0

NB. Pension related benefits is the increase in the annual pension entitlement determined in accordance with the HMRC method. This compares the accrued pension and the lump sum at pensionable age at the end of the financial year against the same figures at the beginning of the financial year adjusted for inflation. The difference is then multiplied by 20 which represents the average number of years an employee receives their pension (20 years is a figure set out in the Department of Health Manual for Accounts, which CCG's are required to follow). Employees' pension contributions in the year are then deducted from this figure.

Pension benefits

The table below shows the pensions benefits of senior managers during the year. An explanation of the figures is provided below the table.

Name and title	Real increase in pension at pension age bands of £2,500	Real increase in pension lump sum at pension age bands of £2,500	Total accrued pension at pension age at 31 March 2016 bands of £5,000	Lump sum at pension age related to accrued pension at 31 March 2016 bands of £5,000	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
David Kelly Chair	0-2.5	2.5-5	10-15	30-35	192	27	222	n/a
Chris Dowse Chief Officer	0-2.5	0	5-10	0	61	32	94	n/a
Steven Brennan Chief Financial Officer	0-2.5	0	25-30	80-85	420	13	438	n/a
Deborah Turner Head of Quality and Safety & Chief Nurse	0-2.5	0	20-25	55-60	285	15	304	n/a

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 beneficiaries) pensions payable from the scheme. CETVs are calculated in accordance with the occupational pension schemes (transfer values) regulations 2008.

Real increase in cash equivalent transfer values
This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Pay multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid member of the Governing Body in NHS North Kirklees CCG in the financial year 2015-16 was £115k - £120k (2014-15, £115k-£120k). This was 3.65 (2014-15, 3.75) times the median remuneration of the workforce, which was £32,086 (2014-15, £31,266).

In 2015-16, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £15,000 to £120,000.

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

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.

Off-payroll engagements as of 31 March 2016 for more than £220 per day and that last longer than six months are as follows:

The number that have existed:	**Number**
• For less than one year at the time of reporting	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	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2016	0

Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016:

Number of new engagements	0
of which	
Number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax and National Insurance.	0
of which	
Number for whom assurance has been requested and received	0
Number for whom assurance has been requested but not received.	0
Number that have been terminated as a result of assurance not being received.	0
Total	**0**

Governing body members:

	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)	17

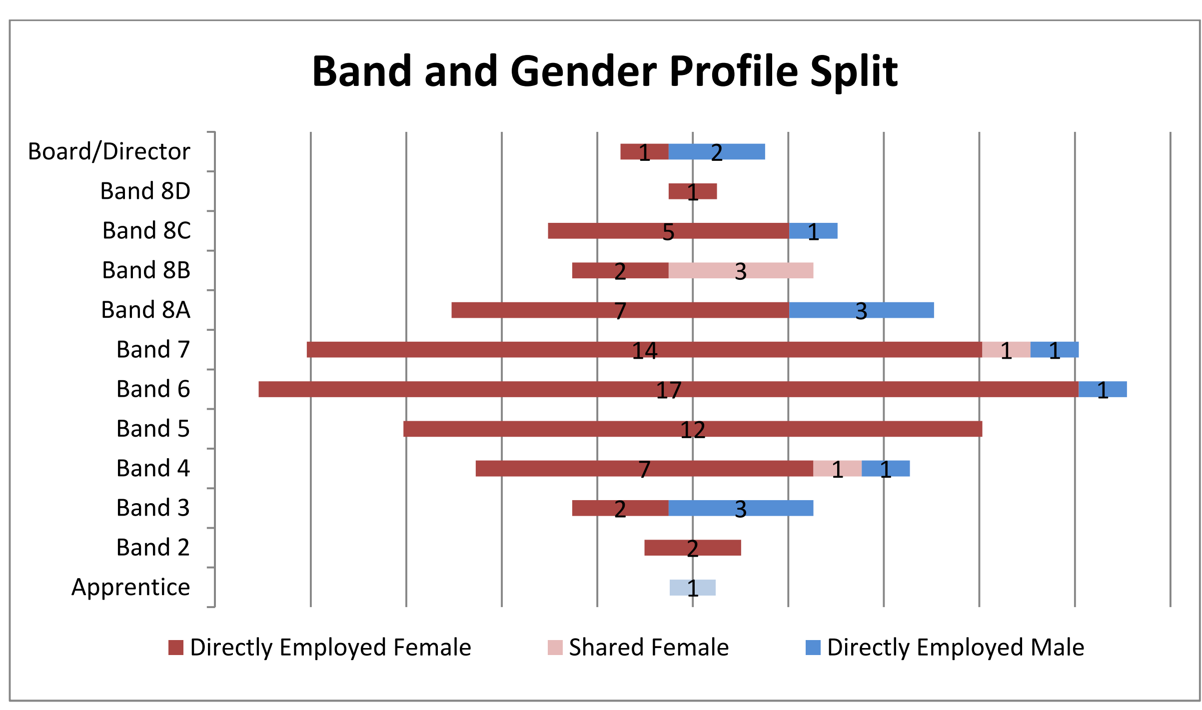
Exit packages and severance payments

There were no exit packages or severance payments during the year.

Analysis and gender distribution of staff

The CCG workforce profile is shown below. Information is based on the directly employed staff as at 31 January 2016. Information relating to Governing Body members is reported separately. Some data is not shared to avoid identification of individuals.

Sex	**Headcount**	**Very senior management (VSM)**	**All other staff**	**Governing Body members**
Female	68	1	67	6
Male	10	1	9	8
Total	**78**	**2**	**76**	**14**



Disabled employees

The CCG takes a positive approach to ensure all employees are treated fairly. We have a range of policies in place and all staff undertake mandatory training which includes modules on equality and diversity legislation. The CCG supports the disability two ticks scheme which guarantees an interview for candidates who declare a disability and meet the minimum criteria for the job.

We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments. The implementation of reasonable adjustments, in partnership with the affected staff member, ensures that disabled employees are fully supported to achieve their potential.

Employee consultation

The action taken by the CCG to maintain or develop the provision of information to, and consultation with, employees, included:

- Providing information on matters of concern to them as employees
- Consulting employees or their representatives on a regular basis so that their views can be taken into account in making decisions which are likely to affect their interests

- Encouraging the involvement of employees in the CCG's performance, development of appraisal process and the introduction of personal development plans
- Achieving a common awareness on the part of all employees of the financial and economic factors affecting the performance of the organisation.

We are committed to ensuring that staff have regular and up to date information about the CCG's on-going and planned work and matters that affect them. We have a range of communication channels including a regular staff briefing, a weekly face to face 'huddle' which is led by senior managers, a written bulletin and ad hoc briefing sessions on key developments. Our intranet supports communication and engagement with staff and we regularly undertake staff surveys. We recently developed a staff wellbeing strategy and action plan. We have an active staff forum with representation from all teams, which considers staff-related issues. A staff partnership forum with representatives from CCG senior management and recognised Trade Unions meets quarterly. A number of events were held during the year in order to ensure that staff were fully involved and engaged in the work of the organisation.

The CCG achieved a national staff survey response rate of 75% compared to 56% 2014/15. An action plan will be developed in relation to findings.

Equality disclosures

Control measures are in place to ensure that all the CCG's obligations under equality, diversity and human rights legislation, and the Health and Social Care Act 2012 section 14T are complied with.

Equality and diversity obligations

We ensure that equality and diversity is a priority when planning and commissioning local healthcare. Our Equality and Diversity Strategy and action plan are designed to ensure that equality is at the heart of all that we do as commissioners and employers. The strategy and plan are reviewed on an annual basis. In addition, we produce an annual report identifying data and other information about local communities and protected groups that has been used to inform decision making. This is reviewed by our Governing Body and published on the CCG website.

Our response to the Equality Act 2010

We welcome the requirements of the Equality Act. We work closely with local communities and use the JSNA to identify needs and aspirations and inform our commissioning priorities.

As part of our business planning process we use detailed equality impact assessments to support decision makers to understand the potential impact and mitigate any negative effects on protected groups.

In line with our public sector equality duty we have identified equality objectives. These are due to be reviewed during 2016. In addition, we have implemented the Equality Delivery System as an equality performance framework to engage local stakeholders and staff to better understand our current position in discharging statutory duties.

All CCG staff and Governing Body members participate in equality and diversity training appropriate to their role. Over the course of the next year, we will put in place mechanisms to assess the CCG's effectiveness with regard to reducing health inequalities.

Policies

To ensure staff do not experience discrimination, harassment or victimisation we have a range of policies and procedures, identified below:

- Equality and Diversity Policy
- Grievance Policy
- Acceptable Standards of Behaviour Policy
- Pay Progression Policy
- Managing Sickness Absence Policy
- Employment Break Policy
- Maternity, Adoption, Maternity Support (Paternity) and Parental Leave Policy
- Flexible Working for Domestic, Carer, Personal and Family Reasons Policy
- Organisational Change Policy
- Managing Sickness Absence Policy
- Education, Training and Development Policy
- Protection of Pay and Conditions of Service Policy
- Recruitment and Selection Policy
- Secondment Policy
- Whistle-blowing Policy
- Travel and Subsistence Policy
- Disciplinary Policy (and procedure)

Equality impact assessments have been carried out on all relevant policies and over the next year the CCG will monitor the impact of the implementation of workforce policies.

Training

All staff and Governing Body members are regularly reminded of their responsibility to complete mandatory training, which includes equality and diversity elements. A presentation on the implications of the public sector equality duty for commissioning health services has been delivered to members of the Audit Committee, senior management team and Governing Body. This ensures the CCG fully considers equality and diversity in the planning process, commissioning intentions, contract management and outcomes framework.

Compliance with the public sector equality duty

Publishing equality information and setting equality objectives is part of the CCG's compliance with the Equality Act (2010) and one of the ways in which we demonstrate how we are meeting the public sector equality duty.

The CCG has specific duties which are intended to drive performance on the general equality duty. The general equality duty requires the CCG, in the exercise of its functions, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited by or under the Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it.
- Foster good relations between people who share a relevant protected characteristic and those who do not share it.

Alongside the activities identified elsewhere in this section and report, we comply with this statutory duty through:

- Active membership of the Kirklees Health and Wellbeing Board
- Active engagement in the development of the Joint Health and Wellbeing Strategy
- Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions

- Testing our five year strategic plan and operational plan against the JSNA and the Joint Health and Well-Being Strategy
- Setting out our equality objectives.

Equality objectives

In line with our public sector equality duty we have agreed three equality objectives for the period of 2013-2017. We intend to review the achievement of these objectives during 2016. Our objectives are:

- Improve the access to psychological therapies (IAPT) for black and ethnic minority people (BME).
- Improve the access, experience and outcomes of older people with Chronic Obstructive Pulmonary Disease (COPD).
- Improve the access, experience and outcomes of South Asian patients with diabetes.

Health and safety

The CCG recognises its responsibility to ensure that reasonable precautions are taken to provide a safe working environment and to prevent or minimise the causes of fires or other health and safety issues, in compliance with relevant statutes and code of practice. During the year a health and safety and fire risk assessment was undertaken which, amongst other things, looked at: the working environment; the systems in place including fire drills and maintenance of warning systems; the information and training provided to staff.

The CCG updated the fire policy and fire escape plan and held two fire evacuations during the year. A sign-in sheet for staff and visitors has been implemented and visitor badges carry health and safety advice. Key safety information is reinforced at weekly staff meetings.

The CCG has not had any investigative referrals during 2015/16.

Signed on behalf of
Chris Dowse
Chief Officer
25 May 2016

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NORTH KIRKLEES CCG

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

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

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

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

Opinion on regularity

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

Opinion on other matters

In our opinion:

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

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

Matters on which we are required to report by exception

We are required to report to you if:

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

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

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

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

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

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

Certificate

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

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

Chartered Accountants
KPMG
1 St Peter's Square
Manchester
26th May 2016

FINANCIAL STATEMENTS

Primary financial statements and notes

The Primary Financial Statements and Notes are included as an appendix to this report.

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Appendix

Appendix 1

These accounts for the year ended 31 March 2016 have been prepared by North Kirklees Clinical Commissioning Group under National Health Service Act 2006 (as amended) in the form which the Secretary of State has, with the approval of Treasury, directed.

Data entered below will be used throughout the workbook:

Entity name:	North Kirklees Clinical Commissioning Group
This year	2015-16
This year ended	31-March-2016
This year commencing:	01-April-2015

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

Please review and adjust to local reporting requirements

Please review accounting policies - some wording has been changed for March 2016 reporting requirements and these have been higlighted in yellow

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31st March 2016	4
Statement of Financial Position as at 31st March 2016	5
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2016	6
Statement of Cash Flows for the year ended 31st March 2016	7

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

	Note	**2015-16 £000**	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	3,662	3,070
Operating Expenses	5	263,098	253,827
Other operating revenue	2	(27,540)	(28,935)
Net operating expenditure before interest		**239,221**	**227,962**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**239,221**	**227,962**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**239,221**	**227,962**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,300	1,925
Operating Expenses	5	2,077	2,698
Other operating revenue	2	(454)	(275)
Net administration costs before interest		**3,923**	**4,348**
Programme Income and Expenditure			
Employee benefiits	4.1.1	1,363	1,145
Operating Expenses	5	261,021	251,129
Other operating revenue	2	(27,086)	(28,659)
Net programme expenditure before interest		**235,298**	**223,615**

Other Comprehensive Net Expenditure		**2015-16 £000**	2014-15 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments			
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**239,221**	**227,962**

The notes on pages 8 to 42 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	**2015-16**	2014-15
		£000	£000
Non-current assets:			
Property, plant and equipment	13	158	130
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		158	130
Current assets:			
Inventories	16	738	300
Trade and other receivables	17	3,523	3,552
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	120	0
Total current assets		**4,381**	3,852
Non-current assets held for sale	21	0	0
Total current assets		**4,381**	3,852
Total assets		**4,540**	3,982
Current liabilities			
Trade and other payables	23	(16,810)	(15,386)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	(364)
Provisions	30	0	0
Total current liabilities		**(16,810)**	(15,750)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,270)**	(11,768)
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		**(12,270)**	(11,768)
Financed by Taxpayers' Equity			
General fund		(12,270)	(11,768)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(12,270)**	(11,768)

The notes on pages 8 to 42 form part of this statement

The financial statements on pages 4 to 7 were approved by the Governing Body on 25th May 2016 and signed on its behalf by:

Richard Parry
Chief Accountable Officer

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

Changes in taxpayers’ equity for 2015-16	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2015	(11,768)	0	0	**(11,768)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(11,768)**	**0**	**0**	**(11,768)**
Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2015-16				
Net operating expenditure for the financial year	(239,221)			(239,221)
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
Trade and other payables	**(239,221)**	**0**	**0**	**(239,221)**
Net funding	238,719	0	0	238,719
Balance at 31 March 2016	**(12,270)**	**0**	**0**	**(12,270)**

Changes in taxpayers’ equity for 2014-15	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2014	**(10,878)**	**0**	**0**	**(10,878)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Commissioning Board balance at 1 April 2014	**(10,878)**	**0**	**0**	**(10,878)**
Changes in NHS Commissioning Board taxpayers’ equity for 2014-15				
Net operating costs for the financial year	(227,962)			(227,962)
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
transfer by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(227,962)**	**0**	**0**	**(227,962)**
Net funding	227,072	0	0	227,072
	(11,768)	**0**	**0**	**(11,768)**

The notes on pages 8 to 42 form part of this statement

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

	Note	**2015-16 £000**	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(239,221)	(227,962)
Depreciation and amortisation	5	31	29
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		(438)	(215)
(Increase)/decrease in trade & other receivables	17	29	2,578
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	1,424	(1,849)
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		**(238,175)**	(227,419)
Cash Flows from Investing Activities			
Interest received		0	0
Trade and other payables		(60)	(92)
(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		**(60)**	(92)
Net Cash Inflow (Outflow) before Financing		**(238,235)**	(227,511)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		238,719	227,072
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		**238,719**	227,072
Net Increase (Decrease) in Cash and cash equivalents	20	**484**	(438)
Cash & Cash Equivalents at the Beginning of the Financial Year		**(364)**	74
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		**120**	(364)

The bank overdraft stated above (14-15 £364k) is not a bank overdraft but a timing difference for transactions that didn't clear the bank until after 1 April 2015.

The notes on pages 8 to 42 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

1.4 **Movement of Assets within the Department of Health Group**

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

1.5 **Charitable Funds**

We do not hold any charitable funds

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.

Trade an

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***

We do not have any critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the entity's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

1.7.2 **Key Sources of Estimation Uncertainty**

There are no key estimations that management has made in the process of applying the CCG's accounting policies that have a significant effect on the amounts recognised in the financial statements.

Notes to the financial statements

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, except for bonuses earned but not yet taken which, like annual leave earned but not yet taken is not accrued for at year end, on the grounds of immateriality

1.9.2 **Retirement Benefit Costs**

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.11.2 **Valuation**

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

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

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

Following initial recognition, intangible assets are carried at 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**

We do not hold any donated assets

1.15 **Government Grants**

We do not have any government grants

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

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

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

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

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

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

1.17 **Leases**

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

Notes to the financial statements

1.17.1 **The Clinical Commissioning Group as Lessee**

We do not hold any finance leases

1.17.2 **The Clinical Commissioning Group as Lessor**

We do not hold any finance leases

1.18 **Private Finance Initiative Transactions**

We do not have any PFI or LIFT transactions

1.19 **Inventories**

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 **Cash & Cash Equivalents**

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

1.21 **Provisions**

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

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

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

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

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

We do not have any transactions relating to this scheme.

Contingencies

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

1.27.1 **Financial Assets at Fair Value Through Profit and Loss**

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

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

1.27.4 **Loans & Receivables**

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.28 **Financial Liabilities**

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

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.28.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.28.2 **Financial Liabilities at Fair Value Through Profit and Loss**

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

1.28.3 **Other Financial Liabilities**

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

Notes to the financial statements

1.29 **Value Added Tax**

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

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

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

1.33 **Subsidiaries**

We do not have any subsidiaries

1.34 **Associates**

We do not have any associates

1.35 **Joint Ventures**

We do not have any joint ventures

1.36 **Joint Operations**

We do not have any joint operations

1.37 **Research & Development**

We do not have any research and development expenditure

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Other Operating Revenue

	2015-16 Total	**2015-16 Admin**	**2015-16 Programme**	2014-15 Total
	£000	**£000**	**£000**	£000
Recoveries in respect of employee benefits	746	316	430	524
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	0	0	0	0
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	678	0	678	631
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	26,116	138	25,978	27,780
Total other operating revenue	**27,540**	**454**	**27,086**	**28,935**

Admin revenue is received that is not directly attributable to the provision of healthcare or healthcare services

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the general fund

Other revenue includes £25.4M Continuing healthcare income from Greater Huddersfield Clinical Commissioning Group. This is a recharge to Greater Huddersfield to recover their proportion of the cost.

3 Revenue

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.

North Kirklees Clinical Commissioning Group - Annual Accounts 2015-16

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2015-16	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	3,110	2,634	476	1,939	1,737	202	1,171	897	274
Social security costs	228	219	8	151	151	0	77	69	8
Employer Contributions to NHS Pension scheme	325	318	7	210	210	0	115	108	7
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**3,662**	**3,171**	**491**	**2,300**	**2,098**	**202**	**1,363**	**1,073**	**289**
Less recoveries in respect of employee benefits (note 4.1.2)	(746)	(746)	0	(316)	(316)	0	(430)	(430)	0
Total - Net admin employee benefits including capitalised costs	**2,916**	**2,425**	**491**	**1,984**	**1,782**	**202**	**933**	**643**	**289**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,916**	**2,425**	**491**	**1,984**	**1,782**	**202**	**933**	**643**	**289**

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,594	2,174	420	1,613	1,413	200	981	761	220
Social security costs	190	185	5	127	127	0	63	58	5
Employer Contributions to NHS Pension scheme	286	279	7	185	185	0	101	93	7
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**3,070**	**2,638**	**432**	**1,925**	**1,726**	**200**	**1,145**	**912**	**233**
Less recoveries in respect of employee benefits (note 4.1.2)	(524)	(524)	0	(237)	(237)	0	(286)	(286)	0
Total - Net admin employee benefits including capitalised costs	**2,546**	**2,114**	**432**	**1,688**	**1,488**	**200**	**858**	**626**	**233**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,546**	**2,114**	**432**	**1,688**	**1,488**	**200**	**858**	**626**	**233**

4.1.2 Recoveries in respect of employee benefits

	2015-16			2014-15
	Total £000	Permanent Employees £000	Other £000	Total £000
Employee Benefits - Revenue				
Salaries and wages	(625)	(625)	0	(445)
Social security costs	(48)	(48)	0	(30)
Employer contributions to the NHS Pension Scheme	(73)	(73)	0	(48)
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	**(746)**	**(746)**	**0**	**(524)**

4.2 Average number of people employed

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**86**	**81**	**5**	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

	2015-16 Number	**2014-15 Number**
Total Days Lost	486	460
Total Staff Years	79	57
Average working Days Lost	**6**	**8**

	2015-16 Number	2014-15 **Number**
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

Where the clincial commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS pension scheme.

4.4 Exit packages agreed in the financial year

There have been no exit packages agreed during the financial year.

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 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 Governement Actuary's Department) as at the end of the report period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation date as at 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend the 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 appropriate employee and employer representatives as deemed appropriate.

For 2015-16, employers' contributions of £325,000 were payable to the NHS Pensions Scheme (2014-15: £286,000) at the rate of 14.3% of pensionable pay. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	3,395	2,032	1,363	2,804
Executive governing body members	267	267	0	266
Total gross employee benefits	**3,662**	**2,299**	**1,363**	**3,070**
Other costs				
Services from other CCGs and NHS England	3,892	1,159	2,733	5,114
Services from foundation trusts	26,998	66	26,931	26,962
Services from other NHS trusts	121,943	0	121,943	119,572
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	72,245	0	72,245	65,519
Chair and Non Executive Members	474	474	0	533
Supplies and services – clinical	1,173	0	1,173	1,045
Supplies and services – general	9	9	0	0
Consultancy services	0	0	0	0
Establishment	186	94	91	244
Transport	4	3	1	2
Premises	2,173	119	2,054	2,211
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	31	31	0	29
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	57	57	0	69
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	30,740	0	30,740	30,590
Pharmaceutical services	0	0	0	0
General ophthalmic services	66	0	66	0
GPMS/APMS and PCTMS	1,279	0	1,279	1,369
Other professional fees excl. audit	35	36	(0)	65
Grants to other public bodies	631	0	631	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	99	27	72	155
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to Group bodies		0	0	0
CHC Risk Pool contributions	1,023	0	1,023	324
Other expenditure	40	0	40	23
Total other costs	**263,098**	**2,077**	**261,021**	**253,827**
Total operating expenses	**266,760**	**4,376**	**262,384**	**256,897**

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

Purchase of Healthcare from Non NHS bodies includes £25.4M of purchases for Greater Huddersfield CCG. This cost is recovered from Greater Huddersfield CCG.

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 **Number**	2014-15 **£000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	17,251	76,763	17,606	70,610
Total Non-NHS Trade Invoices paid within target	15,404	67,376	16,444	65,930
Percentage of Non-NHS Trade invoices paid within target	**89.29%**	**87.77%**	**93.40%**	**93.37%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,181	153,330	1,871	152,741
Total NHS Trade Invoices Paid within target	1,930	147,385	1,348	142,593
Percentage of NHS Trade Invoices paid within target	**88.49%**	**96.12%**	**72.05%**	**93.36%**

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

The CCG has not made any payments under this legislation

7 Income Generation Activities

The CCG does not undertake any income generation activities

8. Investment revenue

The CCG does not have any investment revenue

9. Other gains and losses

The CCG does not have any gains and losses

10. Finance costs

The CCG does not have any finance costs

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

We do not have any functions that transferred to or from another body to report

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

				2015-16				2014-15
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Payments recognised as an expense								
Minimum lease payments	0	2,126	0	**2,126**	0	2,181	0	**2,181**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**2,126**	**0**	**2,126**	**0**	**2,181**	**0**	**2,181**

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

12.1.2 Future minimum lease payments

				2015-16				2014-15
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Payable:								
No later than one year	0	83	0	**83**	0	83	-	**83**
Between one and finve years	0	162	0	**162**	0	245	-	**245**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**245**	**0**	**245**	**0**	**328**	**0**	**328**

Future minimum payments relate to the lease of Empire House, Dewsbury

12.2 As lessor

The CCG is not a lessor

13 Property, plant and equipment

2015-16	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01-April-2015	137	159	296
Addition of assets under construction and payments on account			5
Additions purchased	40	20	66
Additions donated	0	0	7
Additions government granted	0	0	0
Additions leased	0	0	0
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Cost/Valuation At 31-March-2016	**177**	**179**	**374**
Depreciation 01-April-2015	60	106	166
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Charged during the year	22	10	31
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Depreciation at 31-March-2016	**82**	**116**	**198**
Net Book Value at 31-March-2016	**95**	**64**	**176**
Purchased	95	64	158
Donated	0	0	0
Government Granted	0	0	0
Total at 31-March-2016	**95**	**64**	**158**
Asset financing:			
Owned	95	64	158
Held on finance lease	0	0	0
On-SOFP Lift contracts	0	0	0
PFI residual: interests	0	0	0
Total at 31-March-2016	**95**	**64**	**158**

Revaluation Reserve Balance for Property, Plant and Equipment

	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 01-April-2015	0	0	0
Revaluation gains	0	0	0
Impairments	0	0	0
Release to general fund	0	0	0
Other movements	0	0	0
At 31-March-2016	**0**	**0**	**0**

13 Property, plant and equipment

2014-15	Information technology £000	Furniture & fittings £000	Total £000
Cost or Valuation at 1 April 2014	65	139	204
Addition of assets under construction and payments on account			5
Additions purchased	72	20	98
Additions donated	0	0	7
Additions government granted	0	0	0
Additions leased	0	0	0
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Cost or Valuation at 1 April 2015	**137**	**159**	**314**
Depreciation 1 April 2014	40	97	137
Reclassifications	0	0	0
Reclassified as held for sale and reversals	0	0	0
Disposals other than by sale	0	0	0
Upward revaluation gains	0	0	0
Impairments charged	0	0	0
Reversal of impairments	0	0	0
Charged during the year	20	9	29
Transfer (to)/from other public sector body	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0
Depreciation 1 April 2015	**60**	**106**	**166**
Net Book Value at 31 March 2015	**76**	**53**	**148**
Purchased	76	53	130
Donated	0	0	0
Government Granted	0	0	0
Total at March 2015	**76**	**53**	**130**
Asset financing:			
Owned	76	53	130
Held on finance lease	0	0	0
On-SOFP Lift contracts	0	0	0
PFI residual: interests	0	0	0
Total at March 2015	**76**	**53**	**130**

	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 31 March 2014	0	0	0
Revaluation gains	0	0	0
Impairments	0	0	0
Release to general fund	0	0	0
Other movements	0	0	0
At 31 March 2015	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The CCG does not have any assets under construction

13.2 Donated assets

The CCG does not have any donated assets

13.3 Government granted assets

The CCG does not have any government granted assets

13.4 Property revaluation

The CCG does not have any properties

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

The CCG does not have any compensation from third parties

13.6 Write downs to recoverable amount

The CCG does not have any write downs or reversals of pervious write downs

13.7 Temporarily idle assets

The CCG does not have any temporarily idle assets

13.8 Cost or valuation of fully depreciated assets

The CCG does not have any fully depreciated assets

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	3
Furniture & fittings	0	6

14 Intangible non-current assets

The CCG does not have any intangible non-current assets

15 Investment property

The CCG does not have investment property

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01-April-2015	0	0	0	0	0	300	300
Additions	0	0	0	0	0	438	438
Inventories recognised as an expense in the period	0	0	0	0	0	0	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to the statement of comprehensive net expenditure	0	0	0	0	0	0	0
Transfer (to) from -Goods for resale	0	0	0	0	0	0	0
At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**738**	**738**

17 Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	54	0	5	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	3	0	2	0
NHS accrued income	62	0	2,793	0
Non-NHS receivables: Revenue	250	0	497	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	171	0	40	0
Non-NHS accrued income	2,854	0	54	0
Provision for the impairment of receivables	0	0	0	0
VAT	129	0	2	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	160	0
Total Trade & other receivables	**3,523**	**0**	**3,552**	**0**
Total current and non current	**3,523**		**3,552**	
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 clincial commissioning groups to commission services, no credit scoring of them is considered necessary.

17.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	216	205
By three to six months	0	0
By more than six months	85	97
Total	**301**	**302**

The CCG does not hold any collateral against receivables outstanding at the 31 March 2016

17.2 Provision for impairment of receivables

The CCG does not have a provision for impairment of receivables

18 Other financial assets

The CCG does not have other financial assets

19 Other current assets

The CCG does not have any other current assets

20 Cash and cash equivalents

	2015-16	2014-15
	£000	£000
Balance at 01-April-2015	(364)	74
Net change in year	484	(438)
Balance at 31-March-2016	**120**	**(364)**
Made up of:		
Cash with the Government Banking Service	120	(364)
Cash with Commercial banks	0	364
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**120**	**(0)**
Bank overdraft: Government Banking Service	0	(364)
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**(364)**
Balance at 31-March-2016	**120**	**(364)**

The CCG doesnot hold any money on behalf of patients

The bank overdraft (2014-15) of £364k is not a bank overdraft but a timing difference for transactions that didn't clear the banks until after the 1st April 2015

21 Non-current assets held for sale

The CCG does not have any non-current assets held for sale

22 Analysis of impairments and reversals

The CCG does not have impairments or reversals

23 Trade and other payables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,627	0	1,846	0
NHS payables: capital	0	0	0	0
NHS accruals	302	0	367	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	8,601	0	3,703	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	5,667	0	8,970	0
Non-NHS deferred income	0	0	13	0
Social security costs	41	0	37	0
VAT	0	0	0	0
Tax	39	0	38	0
Payments received on account	0	0	0	0
Other payables	533	0	412	0
Total Trade & Other Payables	**16,810**	**0**	**15,386**	**0**
Total current and non-current	**16,810**		**15,386**	

Other payables include £53k outstanding pension contributions at 31 March 2016, (2014-15 £46k)

24 Other financial liabilities

The CCG does not have any other financial liabilities

25 Other liabilities

The CCG does not have any other liabilities

26 Borrowings/Bank Overdraft

The CCG does not have any borrowings/bank overdraft. The bank overdraft stated in the financial position in 2014-15 (£364k) was not a bank overdraft but a timing difference for transactions that didn't clear the bank until after the 1 April 2015

27 Private finance initiative, LIFT and other service concession arrangements

The CCG does not have any private finance inittiatives, LIFT and other service concession agreements

28 Finance lease obligations

The CCG does not have any finance lease obligations

29 Finance lease receivables

The CCG does not hold any finance leases

30 Provisions

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 clinicial commissioning group. However, the legal liability remains with the CCG.

The total value of legacy NHS Continuing Healthcare (£1,375k) and other legacy provisions (£96k) accounted for by NHS England on behalf of this CCG at 31 March 2016 is £1,471K (2014-15 £2,459K)

31 Contingencies

The CCG does not have any contingent assets or liabilities

32 Commitments

32.1 Capital commitments

The CCG does not have any capital commitments

32.2 Other financial commitments

The CCG does not have any other financial commitments

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

The Clinical Commissioning Group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	115	0	115
· Non-NHS	0	3,104	0	3,104
Cash at bank and in hand	0	120	0	120
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**3,340**	**0**	**3,340**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	2,798	0	2,798
· Non-NHS	0	551	0	551
Cash at bank and in hand	0	0	0	0
Other financial assets	0	160	0	160
Total at 31 March 2015	**0**	**3,509**	**0**	**3,509**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,930	1,930
· Non-NHS	0	14,800	14,800
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**16,730**	**16,730**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	2,214	2,214
· Non-NHS	0	13,098	13,098
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	364	364
Other financial liabilities	0	0	0
Total at March 2015	**0**	**15,676**	**15,676**

34 Operating segments

North Kirklees CCG is a commissioner of healthcare services for the population of North Kirklees. This is our only operating segment and the Governing body routinely receives financial performance at this level. This means that no disclosure in respect of operating segments is required under IFRS 8

IFRS 8 also requires entity wide disclosure of information about income from major customers. To comply with these requirements we have provided additional narrative disclosure in Note 2 - Other Operating Income.

35 Pooled budgets

North Kirklees Clinical Commissioning Group has entered into a pooled budget with Greater Huddersfield Clinical Commissioning Group and Kirklees Metropolitan Council. The service is hosted by Kirklees Metropolitan Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the community equipment service.

	2015-16	2014-15
	£000	£000
Gross Funding		
North Kirklees Clinical Commissioning Group	687	544
Greater Huddersfield Clinical Commissioning Group	885	701
Kirklees Metropolitan Council	1,845	1,560
	3,417	**2,805**
Add Balance B/Fwd From Previous Year	771	906
Add B/Fwd surplus adjustment	0	187
Total Funding	**4,188**	**3,898**
Expenditure		
Equipment And Overheads	3,233	2,980
Management Overheads	150	147
Total Expenditure	**3,383**	**3,127**
Net (Surplus)/Deficit	**(805)**	**(771)**

Better Care Fund Pooled Budget

North Kirklees Clinical Commissioning Group has entered into a pooled budget with Greater Huddersfield Clinical Commissioning Group and Kirklees Metropolitan Council. The service is hosted by Kirklees Metropolitan Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund

The clinical commissioning group’s and consolidated group’s shares of the income and expenditure handled by the pooled budget in this financial year are shown below . There are no comparator figures for 14/15 as the pooled fund was agreed from 1st April 2015

	2015-16	**2014-15**
	£000	£000
Gross Funding		
North Kirklees Clinical Commissioning Group	11,858	0
Greater Huddersfield Clinical Commissioning Group	14,697	0
Kirklees Metropolitan Council	2,398	0
Total Funding	**28,953**	**0**
Expenditure		
North Kirklees Clinical Commissioning Group	5,068	0
Greater Huddersfield Clinical Commissioning Group	6,627	0
Kirklees Metropolitan Council	17,258	0
Total Expenditure	**28,953**	**0**
Net (Surplus)/Deficit	**0**	**0**

The CCG has liabilities totalling £868k relating to the Better Care Fund pooled budget

36 NHS Lift investments

The CCG does not have any LIFT investments

37 Related party transactions

Details of related party transactions with individuals are as follows:
Representatives from the GP practices above were members of our Governing Body during 2015/16 and / or 2014/15. Their practices received remuneration from the CCG for services to patients. The amounts involved are disclosed below.

	Payments to Related Party	Payments to Related Party	Amounts owed to Related Party	Amounts owed to Related Party
	2015-16	2014-15	2015-16	2014-15
	£'000	£'000	£'000	£'000
Albion Surgery, Heckmondwike (Dr A Jabbar)	25	18	0	8
Brookroyd Surgery, Heckmondwike (Dr D Kelly)	86	86	0	23
Cherry Tree Surgery, Batley (Dr A Jabbar)	20	17	0	8
Healds Road Surgery, Dewsbury, formerly West Park Surgery. (Dr N Ghafoor /K Greaves)	78	66	0	18
Liversedge Health Centre(Dr N Ghafoor /K Greaves)	27	30	0	10
Mount Pleasant Medical Centre, Batley (Dr K Naeem)	110	114	0	26
Parkview Surgery/Ravensthorpe Medical Centre (Dr Y Mahmood /R Kilburn)	80	92	0	28
The Greenway Medical Practice, Cleckheaton (Dr A Cameron)	67	51	0	17

The remuneration of individual executive governing body members is disclosed with the CCGs' annual report page 51. There were no outstanding balances with members as at 31st March 2016.

Related party transactions with Curo Health Limited during 151/6 totalled £742K. All 29 GP practices are members and have shares in Curo Health Limited.

Tony Gerrard is the Audit Lay member (left 31.10.15) for both North Kirklees and Greater Huddersfield CCG but has no material transactions

NHS England is the parent entity and is regarded as a related party. The Department of Health as the parent department is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are listed below.

	2015-16	2014-15
	£000	£000
Mid Yorkshire Hospital NHS Trust	104,561	102,688
Calderdale and Huddersfield NHS Foundation Trust	5,375	5,200
Leeds Teaching Hospitals NHS Trust	7,929	7,553
South West Yorkshire Partnerships NHS Foundation Trust	17,496	18,118
Bradford Hospitals NHS Teaching Trust	2,685	2,244
Yorkshire Ambulance Service NHS Trust	9,090	8,909
Prescription Pricing Authority	30,740	30,590
Kirklees MBC	15,047	9,853

Income received from Greater Huddersfield CCG is disclosed in Note 2 - Other Operating Revenue

In addition, the CCG has had a significant number of material transactions with other Government Departments and other central and local Government bodies.

38 Events after the end of the reporting period

There are no adjusting or non-adjusting events after the reporting period

39 Losses and special payments

There have been no losses or special payments during 2015/16

40 Third party assets

The clinical commissioning group does not have any cash or cash equivalents which relate to monies held by the clinical commissioning group on behalf of other parties

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:

	2015 - 16 Target	2015 - 16 Performance	2015 - 16 Duty Achieved	2014 - 15 Target	2014 - 15 Performance	2014 - 15 Duty Achieved
Expenditure not to exceed income	270,529	266,821	Yes	261,246	256,897	Yes
Capital resource use does not exceed the amount specified in Directions	60	60	Yes	92	92	Yes
Revenue resource use does not exceed the amount specified in Directions	242,929	242,929	Yes	232,311	232,311	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	Yes	0	0	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	4,301	3,923	Yes	4,987	4,348	Yes

42 Impact of IFRS

There is no impact to the clinical commissioning groups accounts as a result of adopting IFRS

43 Analysis of charitable reserves

The CCG does not hold any charitable reserves

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2016/17

Operational Plan for High Quality Local Services

NHS Greater Huddersfield Clinical Commissioning Group

2016/17 revision

April 16 Version 0.5

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Document History

Document Ref:	Greater Huddersfield CCG Operational Plan 2016/17
Version:	Final v0.5
Date:	April 2016
Classification:	for CCG and West Yorkshire Area Team Review

Change Control

Version:	Date:	Author(s):	Summary of Changes:
Draft V0.1	10th February 2016	N.Ackroyd	Outline framework
Draft v0.2	21st March 2016	J.Lawreniuk/N.Ackroyd	Updated Finance Section
Draft v0.3	21st March 2016	J.Giles	Updated Primary Care section
Draft v0.4	21st March 2016	V.Dutchburn	Updated CC2H Section
Draft v0.5	13th April 2016	N.Ackroyd	Updated following Governing Body

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Executive Summary

Our main focus of our work in 2016-17 is very much a continuation of the work started in 2015-16, and is to continue to commission services that deliver care in a timely way, closer to where people live and, as a consequence, reduce the occasions where hospital admission is required.

During 2015/16 we prioritised the commissioning of our Care Closer to Home service. We worked closely with service users, their families and local organisations to set our aims and ambitions for these services and have undertaken a procurement process to secure the right provider for these services. A new contract was awarded to Locala Community Partnerships and was operational from 1 October 2015.

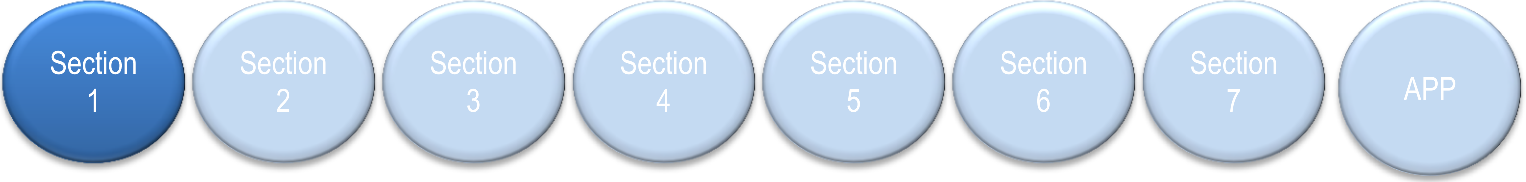
Fundamental to this transformation is the role of primary care, and GP practices. As a membership organisation, we will work with our member practices to help make the changes needed if primary care services in Huddersfield are to be the best that they can be. More information can be found in our **Primary Care Strategy**. During 2015 we have been updating our primary care strategy and will publish the revised version in April 2016 to coincide with our role in fully delegated primary care commissioning

Recent failings elsewhere in the NHS have reinforced the importance of keeping a strong focus on the quality of local services, ensuring they are safe, effective and delivered with care and compassion. Our approach to maintaining and improving quality concentrates on the following major areas:

- Patient experience: – both more effectively acting upon what patients tell us and strengthening their voice in service improvement and in targeting specific aspects of patients' experience, such as personal dignity and communication;
- Safety of clinical services: - targeting areas of concern raised by external or local intelligence including proactive assurance of performance against national standards and ensuring that we minimise unwarranted variation in the quality of service delivery;
- Good clinical practice:- Ensuring that clinicians and services are systematically working to accepted good practice guidelines to help reduce unwarranted variation, and that there are good systems of clinical communication that are timely, accurate, relevant and systematic;
- Agreed pathways of care:- ensuring the effective adoption by primary, community and secondary care services of agreed care pathways in GHCCG, with care indicators that measure the quality of a whole pathway of care; and
- Commissioning intentions: - implementing new models of service delivery and integrated commissioning.

Our financial position remains challenging. Limited increases in NHS funding over the next few years are not enough to cover demand growth, cost inflation, or increases in quality initiatives/better outcomes for patients; as such there is a need for a significant amount of year on year efficiency savings to be made. Over the next two years we need to continue to deliver savings of approximately £4m per annum in order to deliver break even.

We cannot deliver all of our ambitions by ourselves. For the past year, we have worked closely with other organisations in our area as part of the Calderdale and Greater Huddersfield **Right Care, Right Time, Right Place**; this programme will continue to be a key priority for us in the coming months. In 2014, we took the decision to focus initially on our Care Closer to Home model, with the aim of establishing strong community services for our residents. We acknowledged that changes to hospital services will need to be made, but that by getting improvements to community services in place first, we will be in a better place during 2015 to decide if we are ready to consult on any proposals relating to hospital services.



This Operational Plan sets out our priorities over the coming years in response to the Five Year Forward View. It will set out what we plan to do to deliver the vision for our organisation, and support the achievement of shared aims with public sector partners in our area.

The leading national health and care bodies in England have come together to publish 'Delivering the Forward View: NHS Shared Planning Guidance 2016/17 – 2020/21', setting out the steps to help local organisations deliver a sustainable, transformed health service and improve the quality of care, wellbeing and NHS finances. Some of what is needed can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers.

Every health and care system will come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. Each place based footprint will produce a sustainability and transformational plan (STP). The STPs will cover the period between October 2016 and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. The STP will span providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

The STP encompassing Greater Huddersfield CCG will be produced jointly with North Kirklees CCG, to reflect the shared focus we have with Kirklees Council on improving the health and wellbeing of our residents. This document will be published as the Kirklees Sustainability and Transformation Plan. Together, we have a shared picture of the health needs of Kirklees residents in the Joint Strategic Needs Assessment. The Joint Health and Well Being Strategy seeks to address these needs by identifying shared priorities and clear outcomes for improving wellbeing and health inequalities; it also provides a framework and set of tools to support the innovative system changes required. Together, the two CCGs (ourselves and North Kirklees), along with the Council, oversee these shared work programmes in the Kirklees Health and Well Being Board (HWBB). The Better Care Fund plan has also been developed within the same planning footprint and overseen by the Kirklees HWBB.

As a commissioning organisation, we will transform the way our system currently operates so there is a greater focus on the prevention of ill health and the empowerment of citizens who will be able to manage their health and wellbeing and access integrated community, social and primary care services that are connected by effective pathways into acute settings when required. We are supportive of citizen engagement in developing our strategic plans and recognise that Public/patient participation is a key component of all commissioning activities we undertake and developing new models of care. Through the work already undertaken as part of the joint engagement activities to develop the 'Care Closer to Home' model, and the planned engagement activities which will be undertaken as part of the Calderdale and Huddersfield Right Care, Right Time, Right Place programme, we have involved local people in developing our strategic vision for the future, which is described in this document. We have also engaged with our local GP practices.

We are currently developing a new primary care strategy for Greater Huddersfield CCG which outlines the ambition for primary care by 2020 with a supporting implementation plan; the strategy at this stage is focused on general medical services with a view to expanding to including other primary care services in the future. This is being developed through a programme structure working collectively with the LMC and local GP Federations. The work streams for the strategy are focused on describing the primary care offer ('core', 'core plus' and 'advanced') and on the enablers; workforce, IT and technology, estates and engagement. The strategy will be completed for sign-off by the CCG Governing Body in mid-April 2016.

Sustainability and Quality of General Practice

A key component of the strategy is the definition of the provision and standards required as part of a 'core offer' within general practice. The expectation is that all practices will deliver these services and standards to all patients. The aim of this is to reduce the variation and inequity of access and provision between the 37 practices in Greater Huddersfield. Whilst some practices are already successfully fulfilling the requirements and standards, this is not the case for other practices. The strategy outlines a support offer from the CCG to ensure that practices have access to the hands on support, toolkit, best practice and learning locally to enable them to deliver services to the required quality and standards.

The redevelopment of the strategy has been in response to a number of challenges, the most prevalent of these being the sustainability of primary care. Through our engagement with practices in developing the strategy, the key concerns relate to workforce in both recruitment and retention and the available funding for primary care. Workforce is a key component of the strategy identifying not only what will be delivered in primary care, but by who to deliver good clinical outcomes and efficiency. This workstream has identified several priorities for implementation:

- ✓ Alternative roles;
- ✓ Making efficiencies in current roles / processes;
- ✓ Collaboration;
- ✓ Working with / integrating with other services (particularly with community services as part of our new Care Closer to Home services);
- ✓ Retention, recruitment and long-term career and succession planning; and
- ✓ Patient education.

In terms of funding, there is a commitment that any services which move from another setting (e.g. secondary care) into primary care to support provision of Care Closer to Home and efficiencies of service delivery (advanced services) will be supported by funding following from the existing service provision. Receipt of full delegation will support with the redesign of enhanced schemes to fund local priority schemes.

Enhanced Access (OOH, Weekends)

There has been significant learning through the Winter schemes offering extended access to primary care, particularly for urgent appointments working across 5 hubs in Greater Huddersfield. The evaluation of this will continue to inform the commissioning and provision of extended access to services. The CCG is also actively involved within the West Yorkshire Urgent and Emergency Care Vanguard programme, within which there is a workstream looking at urgent access and provision within primary care within the whole of West Yorkshire and Harrogate through the UEC Network.

The strategy has identified enhanced access as a key component of 'core plus' offer and the implementation plan and opportunities afforded by full delegation for commissioning general medical services will identify the approach for implementation and embedding across Greater Huddersfield.

Delegated Authority

The CCG will receive full delegation on 1 April 2016. In support of this, the Primary Care Commissioning Committee will be revised from the current Joint Commissioning Committee. The refresh of the Primary Care strategy will ensure that the decisions of the Committee are in-line with the strategic direction and aspirations for primary care. Part of the delivery plan for the strategy will focus on how implementation can be supported through powers offered by full delegation, particularly to support the 'core plus' offer through redesign of current enhanced schemes.

Our overall vision as set out in the Joint Health and Wellbeing Strategy (link) is that for everyone who lives in Kirklees – "By 2020, no matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality."

The JHWS recognises that whilst there have been overall improvements in local health and wellbeing there are still significant health and care challenges set out in the JSNA (link). The most recent refresh of the JHWS has sharpened the focus on creating an integrated health and social care system that is capable to responding to these challenges. The Health and Wellbeing Board is leading the development of the Kirklees Sustainability and Transformation Plan. The draft objectives are shown in Fig 1, and these draw on the objectives we set out for our first BCF Plan in 15/16 and the NHS 5 Year Forward View.

NHS
Greater Huddersfield
Clinical Commissioning Group

Kirklees 2020 Vision

Objectives for local people

- ✓ People in Kirklees are as well as possible for as long as possible, both physically and mentally
- ✓ People can control and manage life challenges and are able to do as much for themselves and each other as possible
- ✓ People have a safe, warm, affordable home in a decent physical environment within a supportive community and a strong, sustainable economy
- ✓ People take up opportunities that have a positive impact on their health and wellbeing
- ✓ People who are informal carers are identified, supported and involved
- ✓ People experience high quality seamless health and social care that puts their individual needs, choices and aspirations at the heart of their care and support

Objectives for local services

- ➢ The local health and social care system is affordable and sustainable, and investment is rebalanced across the system towards activity in community settings and in peoples own homes
- ➢ Integrated service delivery across primary, community and social care focusses on prevention and early intervention, and are available 24 hours a day and 7 days a week where relevant
- ➢ Strategic planning, commissioning, intelligence, technology, workforce and community planning are fully integrated
- ➢ New solutions are created through innovation and creative collaboration locally, regionally and nationally

The overall population outcome we are aiming to achieve through the BCF plan is:

"People with health and social care needs feel supported and in control of their condition and care, enjoying independence for longer."

This overall outcome is underpinned by four specific person centred outcomes:

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary
- People who receive care, regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support
- People with ongoing support needs manage their condition/needs as well as possible

The key performance measures we will use to measure our progress are:

1. A reduction in Non-elective admissions
2. A reduction in Permanent admissions of older people (65 and over) to residential and nursing care homes
3. An increase in the Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
4. A reduction in Delayed transfers of care from hospital
5. An increase in our Dementia diagnosis rates
6. Patient / service user experience Everyone Involved in my Care knows my Story: (i) Improvement in response Rate on completion of care episode, (ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer NB as this is a new measure there is currently no baseline data.

Each of the specific schemes within the Better Care Fund has been selected on the basis of their contribution to delivering these outcomes, their strategic fit and their impact on our key performance measures.

Over the next 5 years primary, community and social care teams will be commissioned to work together in an increasingly integrated way, with co-ordinated, holistic assessments and rapid and effective joint responses to identified needs, provided in and around the person's home and community. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

In 2016/17 the BCF will be used to build on the joint work already taking place using within the 9 schemes that form part of our overall strategy to deliver these changes:

1. Preventative Services

- continuing to invest in community based prevention and early intervention activities delivered by voluntary and community organisations that support people with their health and social care needs
- building on Kirklees' track record as a leader in self-care, including the development of an innovative web based 'hub' which will transform the way self-care information, support and resources are accessible to a wide range of people
- continuing to support specialist alcohol nurses working in hospitals to reduce alcohol related admissions and repeat presentations for health and care services.
- providing people with long-term conditions who are at risk of hospital admission or needing additional care services with short term support to build their confidence to manage their needs at home

2. Intermediate care (including Reablement Services, Bed Based Intermediate Care Services, Mobile Response Services)

- enhancing investing in and redesigning community based domiciliary services to support admission avoidance and hospital discharge arrangements and integrated crisis and rapid response services to avoid unplanned admission to secondary care services.
- investing in and redesigning where necessary our community bed base to facilitate early supported discharge and/or reduce need for admission to hospital if care can be provided closer to home. This includes additional investment in palliative and end of life care services.

3. Aids to daily living

- our new Integrated Community Equipment Service went live in April 2014, and will work alongside activity on undertaking minor adaptations to property to ensure people are able to stay in their own homes as long as possible

4. Carers Support Services

- investing in carer related support including respite care/short break activity and specified schemes for dementia related care etc.

5. Additional Community Health Services

- Additional investments into Care Closer to Home services enabling patients to remain within their own homes for as long as possible and facilitate their return to their own home as soon as possible should they be admitted to hospital.

6. End of Life

- increasing access to specialist high quality, responsive and holistic service palliative and end of life care for individuals, their carers and families to support personal preferences

7. Psychiatric Liaison Services

- ensuring adults experiencing mental health problems who attend the acute hospitals are sign-posted to the most appropriate care; receive parity of care for physical and mental health needs; are not admitted into hospital just to avoid breaching the emergency care target; and receive on-going psychiatric assessment so that they are ready to be discharged once medically fit.

8. Protecting Social Care

- Ensuring that those people with social care eligible needs can receive the care and support they need to maintain or regain their independence and reduce the risk of hospital admission, recognising that as more people have receive care out-of-hospital they will need additional social care support
- Implementing the Care Act, including the predicted increased volumes of assessments, carers assessment and associated packages of care

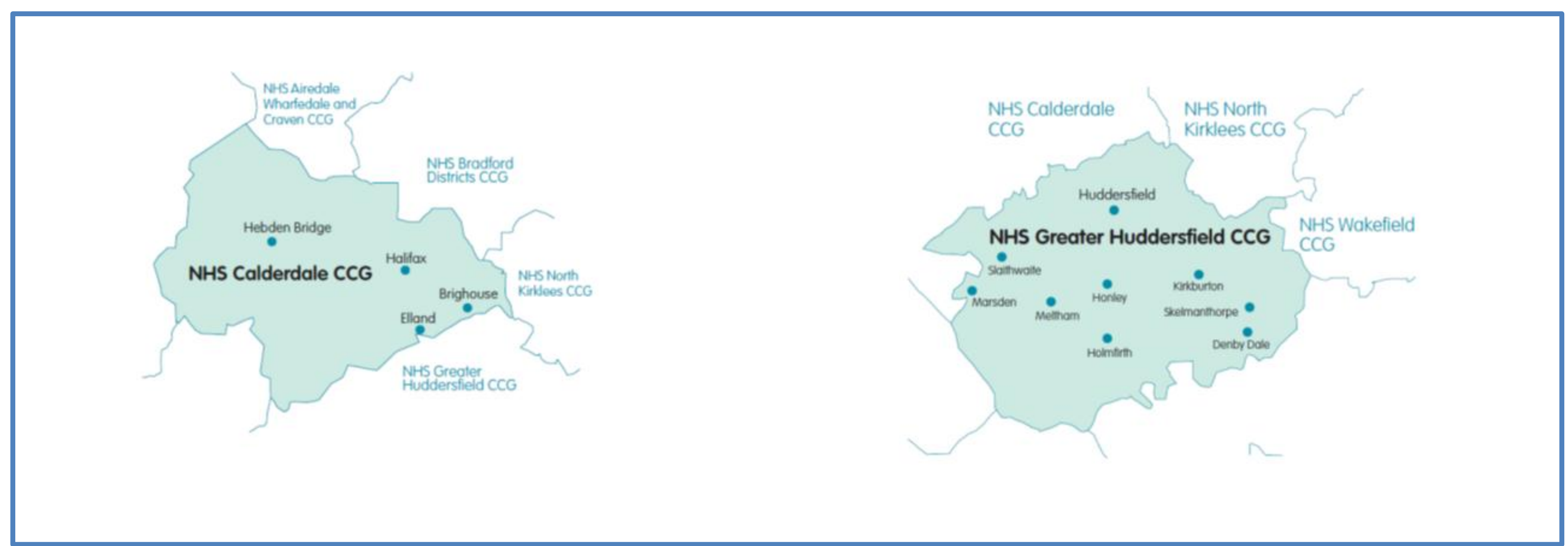
By offering integrated high quality services at times required to meet the needs of the community Kirklees wishes to reduce reactive, unplanned care and do more planned care earlier. The benefits that patients and their carers will see as a result of the changes and how these will impact on emergency attendances and hospital admissions. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers where necessary; ensuring care is co-ordinated and seamless as one coherent package with a focus on helping recovery and promoting independence.

Right Care, Right Time, Right Place

Both NHS Greater Huddersfield Clinical Commissioning Group and NHS Calderdale Clinical Commissioning Group are led by local GPs and it is our role to commission (plan and buy) the majority of hospital and community health services for our local population. It is our responsibility to ensure that the services we commission are high quality, safe and sustainable and that in doing so we manage our budgets efficiently and effectively.

We face substantial challenges to improve hospital and community health services and as such we are now consulting the public on some far reaching proposals.

The areas we cover are shown in the maps below. NHS Calderdale CCG shares the same boundaries as Calderdale Council and NHS Greater Huddersfield CCG and its neighbour, NHS North Kirklees CCG, come within the boundaries of Kirklees Council.



The areas of Calderdale and Huddersfield have seen many changes in recent years with populations and life expectancy increasing. Many people now live well into their 80s and 90s. Modern lifestyles are also creating new health issues. Smoking is still the UK's largest cause of preventable illness and early death. Obesity is increasing and brings health issues such as diabetes and cardiovascular disease.

Clinical commissioning groups and local authorities have drawn up Joint Strategic Needs Assessments (JSNA) which identifies some common themes that drive the health needs of the local populations. For Calderdale and Greater Huddersfield these are:

- **Population Growth:** The population for Kirklees is c. 434,000 and for Calderdale is c. 209,000, giving a combined population of c. 643,000 people. This is forecast to increase by 12% in Calderdale and 13% in Kirklees by 2037; which is consistent with England's expected population growth of 14%.
- **Ageing population:** The populations of Kirklees and Calderdale are ageing: in 2012 there were 102,000 people aged 65 years and over (16% of the population). This is forecast to increase to 169,000 people over the age of 65 years by 2037 (23% of the population). These increases represent a compound annual growth rate of 2% for the 65 plus age group and 0.5% for the full population. This is a significant challenge, as the likelihood of having long term conditions increases with age and so does the likelihood of having multiple conditions, increasing the demand on the health system. Kirklees Joint Strategic Needs Assessment 2013 report that by the age of 55-64, one in four people had at least one of the conditions identified in the Current Living in Kirklees 2012 survey. Additionally, by the age of 75, almost two in three had two or more conditions. In Calderdale and Kirklees it is estimated there are c.2,400 people and c.4,200 people respectively living with dementia. Statistics show that more people in Calderdale are admitted to long-term residential care than in other parts of the country.
- **Levels of deprivation:** There are high poverty and deprivation levels in Huddersfield along with higher rates of unhealthy eating and levels of exercise and higher disease burden. The infant mortality rate for Calderdale is significantly higher than England average (7.7 per 1,000 live births compared to 4.6 per 1,000 live births).
- **Health profiles:** The JSNA for the Greater Huddersfield area identified frailty, emotional welfare, obesity and cardio-vascular disease (CVD) as cause for specific concern locally. Priority areas for Calderdale in their JSNA include the management of long term conditions such as diabetes, asthma and epilepsy, mental health and the abuse of alcohol.
- **Lifestyle factors:** Smoking prevalence and the harm caused by alcohol and obesity is increasing. There is arising childhood obesity and it is estimated that 40% of all illness in Calderdale can be attributed to lifestyle factors. In the Greater Huddersfield area, 52% of adults are overweight or obese and 20% of children are overweight or obese.

The cost of health and social care in Calderdale and Huddersfield is now more than £600 million a year and while that figure is set to continue to grow, increasing demand, inflation and the introduction of new drugs and treatments mean costs are increasing faster. It is not just about how much money we have to spend, we need to look at how we spend it.

The Five year Strategic Plan for Calderdale CCG and the Joint Kirklees five year strategy for Greater Huddersfield CCG set out the focus of a 5 year change programme which will centralise key services to improve outcomes for patients and continue the shift of services and resources from unplanned hospital care to integrated health and social care - delivered in community and primary care settings.

As commissioners, we have developed proposals for what these future Community and Hospital services in Calderdale and Greater Huddersfield could look like. The proposals seek to transform the organisation of care and the infrastructure by which it is delivered and constitute major change under section 244 on the NHS Act 2006.

There are three interlinked pieces of work: Calderdale Care Closer to Home Programme; Greater Huddersfield Care Closer to Home Programme; and the Hospital services Programme.

These proposals will be implemented in three inter-related phases over the next five years:

Phase 1 - Strengthen existing community services in line with the new model of care;
Phase 2 - Enhance community services – which is likely to move more services closer to home.
Phase 3 - Hospital changes.

Phase Three - In-Hospital Services

Calderdale CCG and Greater Huddersfield CCG have been developing their proposals for Hospital Services. In response to: our case for change; what our engagement has told us; our developments in relation to Community Services; the National Clinical Advisory Team's report in 2013; the KEOGH Review; and other emerging evidence and best practice, clinicians from both CCGs and CHFT have reached clinical consensus on a potential outline model of care.

Why change is needed

Our ambition for the quality of care and outcomes delivered for our patients is high: we want to achieve the best outcomes for patients; for patients' experience of health services to be good; and for no harm to occur.

The overarching case for change (developed by the Strategic Review and articulated in the Outline Business Case) is clear – the demand for and cost of local health services is increasing at a time when the economic situation means resources will be limited for some time. If the local system is unable to redesign and transform services in a way that drives up quality within that available resource then our patients will experience poorer outcomes as a result.

Transformation of the current models of service delivery for our population is required in order to:

- Ensure the delivery of consistently safe, high quality care to all patients by meeting hospital standards
- Deliver care in the most appropriate and cost effective setting to meet patients' clinical needs

Aware of the growing pressures, we have begun implementing transformational schemes in order to improve the efficiency and quality of the commissioning and delivery of healthcare services, most notably Phase One – Strengthen Community Services.

Quality and Safety Case for Change

Calderdale and Greater Huddersfield CCGs have articulated their over-arching aims on quality and safety as:

- Above average in comparison to peer groups within 3 years;
- 'Best in class' with peer groups within 5 years;
- Where performance is already above average, the aim should be to be 'Best in class' in comparison to peer groups within 3 years; and
- The Harm free care measure should be 100%, irrespective of performance of other providers.

As CCGs we recognise the need to measure and understand our current position against these ambitions and have discussed through its Quality Committees a set of Hospitals Standards. These Hospital Standards articulate the improvements identified by the CCGs on quality of services and patients' experience of care. These Hospital Standards cover emergency care, planned care, maternity care and paediatric care and have shared ownership with Calderdale and Huddersfield NHS Foundation Trust.

These Hospital Standards (detailed as 'inputs') can be summarised as:

- Improved pathways to best support timely access to senior staff and specialist skills, diagnostics and multi-professional support;
- Improved processes to support patients with their conditions and treatment;
- Clinical protocols with access times to routine investigations will be made available and followed by service providers;
- Improved access to senior clinical staff and improved clinical protocols to reflect co-located services, improved access to diagnostics and reduction in inconsistencies/differences in urgent and elective care pathways and standards and clearly defined responsibilities for Paediatric Assessment Units;
- Midwifery-led maternity pathway, with improved access to obstetric input and support, improved pathways and support to diagnostic and support services, including wider support services, and improved staffing levels, including for women in labour (maternity care); and
- Outcomes for patients on patient experience, compassionate care and safe and sustainable care across hospital services.

NHS Calderdale and NHS Greater Huddersfield Clinical Commissioning Groups (CCGs) are consulting people about some far reaching proposed changes to hospital services and further proposed changes to community health services. We need to understand the views of all patients, public, stakeholders and staff who live and work in Calderdale, Greater Huddersfield and others who for whom the proposed changes may have a direct impact (which may include patients, public and stakeholders in surrounding areas) about the way in which Emergency and Acute Care, Urgent Care, Maternity Care, Paediatric Care, Planned Care and Community Health Services are provided in the future.

This is so that by the end of September 2016 both CCGs can make an informed decision on progressing the future shape of hospital services ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients, as well as on which services should be provided in the community, closer to where people live.

These proposed changes would secure the future of health services for both areas for the next 20 years. They would make sure that our hospital services were in line with national recommendations and guidance. They would also mean that more services were provided in the community, including some outpatient clinics, so that people only needed to go to hospital when they really had to be there.

Our proposed changes would help us to address some big challenges.

Currently our patients don't always receive the best possible care. Our hospital services are stretched, with some being split between Calderdale Royal Hospital (CRH) and Huddersfield Royal Infirmary (HRI) sites. Some don't meet national guidance, such as those for children and young people in emergency care. We transfer sick people between hospitals on a daily basis so they can get the care they need. We need to improve our hospital mortality rates which means reducing the number of patients who die in our hospitals. We have difficulty recruiting doctors and therefore rely heavily on temporary (agency) doctors. Like other places around the country, we have an increasing number of older people living longer, often with more than one long term condition who need the right care and support to help them stay well and independent. We need to move with advances in medicine and technology and make sure that our patients get access to the latest treatments.

Alongside all of this we have big financial challenges, which mean we need to make substantial savings so that we can manage within the money available to us as well as achieving the improvements needed going forward.

Our proposed changes are the result of local discussions that began over three years ago to develop a new model of care to resolve some of these challenges. And we have been clear that leaving services as they are would not allow us to deliver the quality of care that local residents deserve, nor would it provide either of our hospitals with the financial sustainability needed to deliver that care.

During our early discussions with patients, the public and our partner organisations, a very clear message received was that before any changes could be made to our hospitals, there needed to be considerable improvements to community services. People said they wanted as much care as possible provided close to home. They wanted more and better services in the community to help them stay well and independent. They wanted these services to be more joined up which would mean health and social care organisations working much more closely to meet the needs of individual patients and to save patients and their families from having to find their way through what can be a very complicated system.

And this is exactly what we have done. We listened and used local feedback to shape our plans to enhance and strengthen community services. As such, Care Closer to Home programmes are being delivered in both Calderdale and Greater Huddersfield which are already transforming the way that care is provided to the people who need it most, particularly elderly and frail people, those living with long term conditions such as heart disease, chronic chest conditions and diabetes and children with complex needs.

These are making great progress and are supporting people of all ages to stay well and independent and we want to do more to make sure that people receive the care they need at home or in the community and are admitted to hospital only if they really need to be there. When they do have to come into hospital we want to make sure that patients can be discharged as soon as they are well enough with the right support at home.

While we have been laying the foundations for strong community services we have been developing a model for hospital services. In shaping this model there have been many more discussions with patients, the public and local organisations and with hospital doctors and nurses, GPs and other healthcare professionals working in the community. We have also had two independent reviews from expert clinicians.

We are proposing investments at both of our hospital sites, so that they become state of the art hospitals. CRH would become an Emergency Centre and the Acre Mills site at Huddersfield a dedicated hospital for planned care. We are also proposing to develop Urgent Care Centres at both hospitals. These developments would cost more than £291m but would generate efficiencies to close the financial gap the system is facing.

The Emergency Centre would bring together on the CRH site all of the emergency and acute services that people need when they become seriously ill or have injuries which can be life threatening. It would also have the services people might need when they become unwell and are admitted to hospital for tests and treatment. We would have a Paediatric Emergency Centre which brings together in one place all of the medical and surgical services for children. We would also continue to have consultant-led maternity services at CRH, again so that they could be in the same place as all of the necessary supporting services should these be needed.

The Urgent Care Centres would be open 24/7, staffed by doctors and emergency care nurses and would have x-ray facilities. These would be the front door to care for people who make their own way to hospital with injuries and illnesses. However, while patients could decide themselves to go to the Urgent Care Centres we would be encouraging them to ring NHS 111 first so that they go to the right place first time and get the care they need as quickly as possible.

The new hospital development on the Acre Mills site at Huddersfield would be for routine procedures and operations that don't need to be done as emergencies but still should be done as soon as possible. This would be a big development with around 120 beds and ten new operating theatres.

We know that people will have questions about our proposed changes and we look forward to meeting with local people and explaining why we feel that this is the right model for hospital services going forward.

The CCGs' GP leaders and the senior clinical staff at Calderdale and Huddersfield NHS Foundation Trust have worked together to develop this new model and support the proposed changes.

7 day services

NHS Services open seven days a week: everyday counts, November 2013.

www.nhsiq.nhs.uk/.../every-day-counts-seven-day-services.aspx

In this guidance, NHS England sets out new clinical standards which describe the standard of care all patients should expect seven days a week, each supported by clinical evidence and developed in partnership with the Academy of Medical Royal Colleges. They describe, for example, how quickly people admitted to hospital should be assessed by a consultant, the diagnostic and scientific services that should always be available, and the process for handovers between clinical teams.

Through both patient and clinical engagement events we have identified services that are required on a 24/7 basis and those that are not. We will continue to refine service provision through a lead provider model delivering our Care Closer to Home strategic vision. General practices will be the cornerstones of care organising inputs from integrated health and social care services to get the best outcomes for their patients, with a greater range of care locally, 24 hours a day, 7 days a week.

The hospital changes detailed proposes to have Urgent Care Centre, available 24/7.

Reducing excess deaths

The number of patients dying in our hospitals is higher than average. The Trust's hospital mortality rates are higher than the England average. This means that more people are dying in our hospitals than would be expected. There is an increased national focus on mortality which means that many more acute Trusts are making significant progress. This brings down the overall England average so that Trusts that are currently outliers, such as Calderdale and Huddersfield NHS Foundation Trust have to reduce mortality even further to move closer to the national average.

Mortality: CHFT's most recent mortality figure is 113 (HSMR one-year rolling data to June 2015). The Trust's most recent SHMI mortality figure was 108.9 (March 2015), against an expected benchmark of 100. Whilst the Trust did achieve a reduction in its mortality rate during 2014-15, it is not been able to narrow the gap to a mortality rate (HSMR) of 100, the accepted national standard for which acute Trusts aim. The reduction was also not sustained in 2014-15 and the mortality rate is back to the near 107 mark from the start of the year3. During the last two years, a national focus on mortality means that many more acute trusts have made significant progress in mortality, bringing down the overall England average and means that Trusts that are currently outliers, such as CHFT, have to reduce mortality even further in order to move closer to the national average – just to move in to the 'as expected' range.

In numerical terms, and in relation to the CCGs' position and outcomes for the CCGs' patients, it can be anticipated that 2015-16, on the current configuration of services, would deliver a reduction in mortality, based on targeted work on acutely ill patients and earlier interventions in sepsis care and medication administration, but not predicted to be at the 100 national benchmark rate and whether reductions are able to be maintained.

Bringing Services and Support Closer to Patients

Greater Huddersfield CCG began to develop the plans to shift services and resources closer to people's homes in 2012, the result of which is a flagship collaborative (with North Kirklees CCG) programme which manages the transition from hospital to community with Phase one services going 'live' on 1 October 2015.

From the outset the Care Closer to Home programme was developed based upon intensive and wide engagement with patients, GP member practices, the public, professionals and partners. Our engagement work told us that people wanted services that are delivered closer to people's homes (although not necessarily within a patients' home) and ensure that fewer people are admitted to hospital.

The vision of how the services should be delivered required dialogue with providers to enable the most economically advantageous and innovative services to be commissioned whilst ensuring collaboration and, where appropriate, joint services across the Kirklees area.

Together with North Kirklees CCG we undertook a joint procurement exercise during 2014 culminating in the appointment of a lead provider for Care Closer to Home, finalised during July 2015. Locala Community Partnerships in conjunction with partners, commenced delivery of the new Care Closer to Home service on 1 October 2015.

The Integrated community service model with its emphasis on the role of helping people to stay healthy and shifting the balance towards prevention and support for people with complex needs, will contribute towards the priorities of the Kirklees Health and Wellbeing Board

Population Covered

NHS Greater Huddersfield CCG is responsible for commissioning health care services for a registered population of approximately 245,000 people across 39 GP practices.

The population is rising and will continue to grow, especially in the older age groups. This creates health and social care challenges as more people live longer and with long term conditions, and it brings economic and social challenges as the proportion of working age people reduces. 1 in 6 of the adult population and more than 1 in 4 under 18s are of south Asian ethnicity.

By 2030 the population of Greater Huddersfield will be 278,700. 16% of the current population is aged 65 years or over, 7.2% is over 75 years old. By 2030, people aged over 65 are expected to make up a quarter of the population – a 70% increase from 2010 to 2030.

Dementia accounts for more years of disability than any other condition. It is estimated that in Kirklees nearly 4,500 people aged over 65 had dementia in 2012, and that this is projected to rise to nearly 5,500 by 2020. Approximately 2/3 of these individuals will be supported in the community and are likely to require treatment/support for other long term physical and mental health conditions.

There is now an increasing need for services that promote independence and wellbeing for patients. Delivery of effective services across Greater Huddersfield will require an integrated approach involving health, social care and third sector organisations.

What is the model?

The Care Closer to Home vision is for integrated community-based healthcare services for all, from children and young people through to and including the frail, vulnerable and older people and also end of life care. It is crucial that we make lasting changes to our health and social care system to ensure that services are fit for purpose and sustainable in the future. Key characteristics of Care Closer to Home are:

- Improved primary and community care providing the right care at the right time in the right place
- Provision of services in the community that promote independence and wellbeing for patients so they can support themselves by exercising self-management, choice and control
- Integrated high-quality services at times required to meet the needs of the community
- Providing more planned care earlier thereby reducing reactive, unscheduled care
- Care provided as one coherent package, with a focus on individuals and helping people to get better

The main elements of the model are:

- Risk assessment to identify people who are most vulnerable and most likely to be admitted to hospital
- Proactive care management by multi-disciplinary teams
- High quality local information and support to enable people to manage their own condition and access the most appropriate care
- Person centred care delivered through a single assessment process and single care plan 24/7
- Care at or near home wherever possible

The overall ambition for the Care Closer to Home Service is outlined below:

- Care is co-ordinated and seamless
- Nobody is admitted to or will remain in hospital or residential care unnecessarily
- People are supported and in control of their condition and care, optimising their independence to enable them to live better quality lives for longer

The following list shows the overarching national principles:

- Reducing avoidable emergency admissions for those conditions that are amenable to healthcare
- Reduction in the need for urgent care

- Reduction in time spent in unnecessary days spent in hospital
- Increase in health related Quality of Life for patients with long term conditions, including mental health
- Value for money
- Increased patient and carer satisfaction with services, including improved responses to the Friends and family Test for local services
- Reduced mortality - potential years of life lost for conditions amenable to healthcare

The outcomes for care closer to home which have been developed with local stakeholders, including patients and carers, are:

- I'm seen at the right time by the right person
- More of my care happens nearer to home
- Me and my carers know how to manage my health and wellbeing
- Everyone involved in my care knows my story

Vision of the model

The vision for Greater Huddersfield CCG is to ensure delivery of integrated services through the model commissioned. That our primary and community care can provide the right care in the right place, at the right time, first time, by staff with the competencies and skills to meet the needs of patients/service users, which compliments and works together with acute care services. By offering integrated high quality services at times required to meet the needs of the community we will reduce reactive, unscheduled care and do more planned care earlier. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers; providing a flexible pattern of delivery across health and social care and the wider partnerships and assets within local communities, ensuring care is co-ordinated and seamless as one coherent package with a focus on prevention, helping recovery and promoting independence.

The key functions of the Care Closer to Home Service are:

- Initial contact handling for any health or social care worker or patient/service user to include contact handling; information gathering within given parameters; using information to determine next steps; referral; involvement of clinical/professional senior decision making;
- Providing professional and clinical decision making and accountability;
- Managing resource allocation and demand;
- Prioritisation, delegation and transfer of care;
- Proactive tracking and care navigation throughout the whole patent/service user journey;
- Proactive reviewing of the effectiveness and efficiency of the care pathway.

An important part of doing things differently in greater Huddersfield, is how we refocus health and social care to help people do more to help themselves, whatever their level of vulnerability or ill-health.

Vision for Self-Care

The vision is that people are increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improving their wellbeing and lifestyle.

The principles for self-care are to:

- Ensure people who use services are able to have greater control and be empowered to co-produce their support plans.
- Raise knowledge so front-line staff have the opportunities to develop and apply 'practical skills' in self-directed support.
- Motivate, encourage and support people to feel confident in their approach to managing their health and wellbeing.
- Embed the importance of 'information' and 'sign posting' - as a route to self-care opportunities for people with long term conditions.
- Further the role of Assistive Technologies for people using at home services.

We have recognised that there are four enablers for achieving better self-care:

- **Skills**; self-advocacy, goal setting, motivational support to increase self-awareness, resilience, understanding psychosocial needs and identifying and managing risks, creating a self-authored management plan
- **Resources;** accessing information and networks so people, their families and carers can talk to others in similar situations. Also information technology, development of skills, knowledge, getting help and monitoring own health
- **Behavioural and cultural change in systems** Timely, consistent and effective experience of support, enable risk management and risk taking to maximise independence and choice. Organisations need to put in resources to support this emphasis across their staff, IT and management systems
- **Communication;** at the front line with an individual, throughout services and across communities

Care Closer to Home Service Description

Through the ongoing implementation, primary and community services are being brought together and provided by linking with appropriate professionals across health and social care using staff and resource flexibly which will be provided at a variety of levels such as:

- Primary care involving local GPs and practice nurses
- Community care; promoting the independence and wellbeing of individuals
- Integrated working between community health provider and third sector /social care providers
- Specialist care; giving access to specialist services

- Medicines Management and Community Pharmacy
- Minor injuries type care in the community, for example staff are able to deal with a skin tear preventing an un-necessary trip to A&E

Supporting proactive prevention, the 'crisis intervention' and 'early supported discharge' elements will be managed through a 'crisis co-ordination' / single point of access facility that will help field initial calls/referrals for intervention, advice and support. The model also embraces the principles and scope of a frailty and intermediate care model, these principles thread through all aspects and elements of the services rather than being individual services which require specific criteria to be met.

We are currently exploring the opportunities offered through Personal Health Budgets and work alongside social care Direct Payments.
Primary care is an essential part of integrated care providing a cornerstone of the locality teams and working with partners to assess and meet the needs of the population. With patient consent and full discussion with patients and carers, multidisciplinary teams are working together in a better, coordinated way to assess need, plan and implement plans to ensure the provision of the best possible services for each patient. There will be individual health and social care summaries available for patients with the key information available to all providers 24hrs a day, seven days a week, as appropriate to meet clinical need and reduce the need for unnecessary hospital admission.

Ongoing Service Phasing Plan

We are well on our journey to achieve **Phase one** of our plan – A strengthened community model has been procured and has started to deliver robust, enhanced community-based health services.

We have developed a Service Improvement Plan, with our service provider to move into **Phase two -** To further enhance community services and begin to move services out of hospital that can be provided more appropriately in the community. Working with our Provider(s) we are continuing with stakeholder engagement to ensure that service improvements are being delivered in the most appropriate way and that risks and potential unintended consequences are identified and mitigated.

Our approach to Quality, Safety and Engagement

What do we need to achieve in 2016/17?

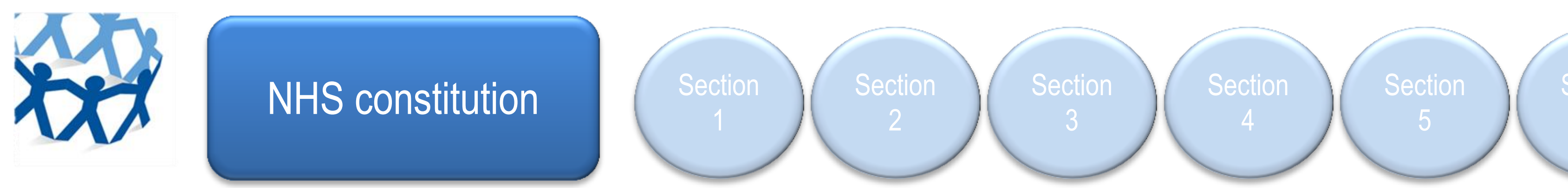
- Services are safe, effective and provide a good experience ensuring that recommendations from significant national reviews are embedded
- Measures and processes in place to monitor the effect of current services and future reconfigurations to ensure that safety is maintained or improved
- Patient and public experience remain central and visible to all our planning and service delivery
- Safeguarding remains an integral part of our business ensuring that the safeguarding standards are implemented for each commissioned service.
- Implement the process for gaining deprivation of liberty authorisations from the Court of Protection for health funded domestic / supported living placements
- Ensure we include any learning from Year 1 of FGM mandatory reporting
- Introduce mortality reviews in primary care, in order to strengthen learning
- Deliver 7 days services where appropriate
- Improve access to General Practice and grow the medical and nursing workforce.
- Continue to promote 3rd Sector organisations as a partner in care delivery
- Deliver fit for purpose and sustainable models of urgent and emergency

What actions do we need to take?

- As service changes take place in line with the Right Care and Care Closer to Home programmes we will have measures in place to monitor the effect of the changes and ensure that safety is maintained or improved as a result of the service change, including the provision of seven day services
- Through our Patient and Public Engagement and Experience Strategy, we will continue to develop relationships within the community and maintain dialogue on existing services and in the planning for future service delivery
- Consider and develop proposals to implement the General Practice Nursing Career Framework in Greater Huddersfield to improve recruitment and retention of the nursing workforce in Primary Care
- Establish and implement mechanisms with General Practice to ensure that when things go wrong, we can demonstrate that the lessons learned are spread rapidly across the system
- Deliver CCG Safeguarding Policy (adults and children), including West Yorkshire agreed processes, MCA and DoLS
- Ensure we address learning and monitor implementation of change following CQC Inspection of our provider services

How will we measure success?

- Further develop dashboards to ensure the ability to monitor safety and patient experience measures across the local health economy
- have measures in place to monitor the effect of the changes and ensure that safety is maintained or improved as a result of the service change, including the provision of seven day services
- Increasing numbers of the population of Greater Huddersfield will be reporting a positive experience when coming into contact with local health services
- Safe, effective services will be delivered over 7 days
- An increased number of 3rd sector providers will partners in the delivery of health care having completed accreditation on the Quality for Health programme
- Deliver 62 day cancer waiting times and 1 year mortality
- Access to general practice will be improved across Greater Huddersfield
- More services will be delivered closer to where people live and work
- Learning from incidents in general practice will be shared across the member practices
- Avoidable mortality will be reduced across Greater Huddersfield
- All commissioned providers are able to demonstrate compliance with safeguarding standards
- Working towards reducing the number of excess deaths at weekends through meeting clinical standards



The 'must dos' for 2016/17 for every local system:

1. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

   Calderdale and Huddersfield Foundation Trust (CHFT) delivered the 95% access time for A&E in Quarters 1-3 of 2015/16. Performance in Quarter 4, January through to March has presented a significant challenge. Through the Urgent Care Board and System Resilience Group, performance is monitored through a dashboard where partners come together to discuss the system wide cause and impact. In 2016/17 we will ensure the system is working together collectively and holding itself to account for improvements in patient care and ways of working – particularly during periods of system pressure. We will continue work on enhancing our system dashboard that provides oversight of; demand, access and quality.

   Yorkshire Ambulance Service (YAS)…………………

2. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

   CHFT delivered the national standard for 18 weeks referral to treatment consistently throughout 2015/16. Performance across all providers was variable but overall Greater Huddersfield CCG also delivered the access standard. This meant that 92% of patient's in Greater Huddersfield waited no longer than 18 weeks from referral to commencing treatment. In 2016/17 GHCCG will consult the public on new models of hospital based planned care ensuring that the views of those patients using the NHS are expressing their views. We will continue to ensure the system is working together collectively and holding itself to account for improvements in patient care and ways of working – particularly during periods of system pressure. Together with Calderdale CCG, we will continue to lead the multi-agency Elective Care Improvement Board to ensure the entirety of the system's capacity is utilised to meet demand with use of a system dashboard that provides oversight of; demand, access and quality.

3. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

   Performance against all cancer waiting time standards has been achieved consistently throughout 2015/16 for Greater Huddersfield patients.

   What will we do in 2016/17?

   - ✓ Continue to work with Healthy Future programme to ensure alignment of plans across West Yorkshire;
   - ✓ Work with our member practices to implement the NICE suspected cancer guidance;
   - ✓ Raise awareness of cancer screening programmes and encourage uptake;
   - ✓ Work with NHS England on the recommendations set out in the National Cancer Strategy; and
   - ✓ Work with partners to develop the model for cancer as part of care closer to home.

4. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

   Parity of Esteem – we will ensure that there remains a focus on mental as well as physical health to ensure that patients with mental health problems do not suffer inequalities. We have enhanced our Mental Health Liaison Team Service to ensure that it meets the core national standards. Through our joint commissioning arrangements we are committed to the integrated approach to commissioning across Adult's and Children's Health and Social Care and Public Health. We will continue to work with our partners prioritising the integrated commissioning group for Emotional & Mental Wellbeing and Independence including learning disability, mental health, emotional wellbeing etc.

   What will we do in 2016/17?

   - ✓ We will improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health;
   - ✓ We will continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase;
   - ✓ We will agree an implementation plan with a provider that delivers the EIP access standard;
   - ✓ We will secure additional years of life for the people of England with treatable mental and physical health conditions;
   - ✓ We will improve the health related quality of life for the 15 million plus people with one or more long term condition, including mental health conditions;
   - ✓ We will continue to increase the number of people with mental and physical health conditions having a positive experience of care outside of hospital, in General Practice and the community; and
   - ✓ We will support the Local Authority in the retender of the CAMHS

5. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

   The Calderdale, Kirklees, Wakefield and Barnsley (CKWB) Transforming Care Partnership has been formed to collaboratively develop a programme that will transform our community infrastructures and reshape services for people with a learning disability and autism. The plan will be framed around Building the Right Support and the National Service Model October 2015 and it will be developed to ensure the needs of the five cohorts below are included as well as the wider population when transforming services.

   1. A mental health problem, such as severe anxiety, depression or a psychotic illness which may result in them displaying behaviours that challenge;
   2. Self-injurious or aggressive behaviour, not related to severe mental ill-health, some of whom will have a specific neurodevelopmental syndrome with often complex life-long health needs and where there may be an increase likelihood of behaviour that challenges;
   3. 'Risky' behaviour which may put themselves or others at risk (this could include fire-setting, abusive, aggressive or sexually inappropriate behaviour) and which could lead to contact with the criminal justice system;
   4. Lower level health or social care needs and disadvantaged backgrounds (e.g. social disadvantage, substance abuse, troubled family background), who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system; and
   5. A mental health condition or whose behaviour challenges who have been in inpatient care for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

   The CKWB region was rated as the 6th highest for CCG commissioned inpatient beds in July 2015 and although work has been ongoing and the number has reduced, we are still well over the national planning assumptions for inpatient beds. For NHS England commissioned beds, the region was mid table, but following several discharges since July 2015, the numbers are now within the national planning assumptions.

Each area within the partnership had already developed programmes locally to transform services, but it has been acknowledged that the partnership will prove invaluable to harness the collective knowledge and experience to further build on progress already made and to use our resources more effectively and efficiently to gain more momentum in the delivery of new models of care and support for the most complex people.

The key aims for our plan will be:

- ✓ Reduction of inpatient beds, delivering a 60% reduction across the partnership by 2019
- ✓ Developing better/new/broader range of specialist community services that are flexible and responsive to manage crisis better and prevent admission
- ✓ Developing capable communities to enable people to live in their own homes
- ✓ Developing a better understanding of our local populations with complex needs and how best to support them in a crisis
- ✓ Ensure people with a learning disability and autism have the opportunity to live meaningful and fulfilled lives

Population and Demographics

Area	Total population	Adult population	LD/Autism Population	LD/Autism known to services
North Kirklees CCG & Greater Huddersfield CCG	434,000	335,826	7,912	1,530

There are currently 12 people in inpatient beds in Greater Huddersfield, this is more than double the national planning assumption level, however by the end of year 1 this will have reduced by 45% and by the end of year 2 we will have achieved better than the levels suggested of inpatient beds across the partnership.

Care and Treatment Reviews

Care and Treatment Reviews (CTR) have been developed as part of NHS England's commitment to transforming the services for people with learning disabilities and/ or autism who display behaviour that challenges, including those with a mental health condition. The CTR ensures that individuals get the right care, in the right place that meets their needs, and they are involved in any decisions about their care.

What a CTR covers

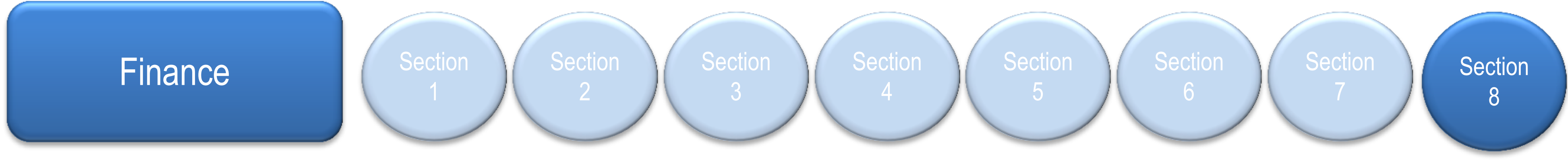
The CTR focuses on four areas: is the person safe; are they getting good care; do they have a plan in place for their future and can their care and treatment be provided in the community. They are carried out with:

- people receiving care in a specialist learning disability or mental health hospital – to see if they can move to a community setting;
- people who are at risk of being admitted to a specialist hospital – to see if there are any other options to prevent an admission; and
- for people who do need specialist hospital care – to ensure they have a care plan with clear outcomes from the start, that focuses on transferring them back to a community setting as soon as they are ready, to prevent unnecessarily lengthy hospital stays.

The CTR team involves the commissioner and two expert advisors – an individual or family member with experience of learning disability services (an 'expert by experience') and an independent clinician – to ensure that care plans meet individuals' needs. It also involves those who are providing their current care. Following the CTR, the review team makes recommendations, with follow-up checks to ensure the activity is being delivered.

The developments for LD and ASD align with the transformation to develop an early response and support for children and young people, and will support a reduction in in-patient services and minimise the impact of pre-admission CTR (care and treatment review).

The Care and Treatment reviews will ensure a clear and co-produced pathway and personalised and flexible packages will be available to ensure the transition is appropriate to meet the individual's needs. Personal health budgets will be offered whenever appropriate as the default choice for procuring a package to support the individual.



- There is a requirement to make long-term financial savings which make the system viable and sustainable
- Our system is over-reliant on emergency unplanned hospital activity compared to the rest of the country with high levels of 'avoidable' admissions
- By 2021/22 the financial challenge facing the area of Calderdale and Greater Huddersfield (health sector only) amounts to £281m
- There are significant social care financial challenges which impact both on the delivery of front-line care and investment in prevention & healthy lifestyle, and supported self-care interventions
- The 2016/17 financial plan is more challenging than in previous years. It includes:
  - An allocation uplift of £8.6m
  - Draw down of £2.9m of our cumulative surplus
  - A £1.6m (0.5%) contingency fund to manage in year risks
  - A £3.2m (1%) non recurrent reserve
  - A £3.7m QIPP requirement (building on the Right Care approach)
  - Delivery of a break-even position in year.
- We have developed a recovery plan that sets out how we will deliver finance sustainability
- We continue to work collaboratively with our main providers to ensure a joined up approach to financial planning and a joint understanding of the system financial position.

RISK

We are currently developing a full view of risk for 2016/17
The table below provides a high level summary of risk related to our current Board Assessment Framework (BAF)

Risk
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
We do not improve health outcomes in line with our plans due to a lack of focus on the wider determinants of health and/or a failure to ensure we have the support of partners, stakeholders and the public
We do not improve patient experience in line with our plans due a failure to use appropriate PPE intelligence to support service improvement and plans to change service models
We do not deliver improvements in independence and recovery for our population due to a failure to focus on improving care and people with long-term chronic conditions (physical and mental health), those who are at risk due to their frailty and children with complex needs.
We do not deliver health improvements for our population due to our failure to commission services to prevent ill health and encourage supported self-management, particularly services in primary and community settings.
We do not deliver improvements in health and well-being due our failure to address significant workforce pressures, particularly within clinical settings
We do not deliver financial sustainability within our system due to reduced financial allocation and a failure to deliver significant QIPP/avoidable admission reduction targets.