NHS
North Kirklees
Clinical Commissioning Group

Annual report and accounts 2015/16

For longer, healthier, happier lives

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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.

[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

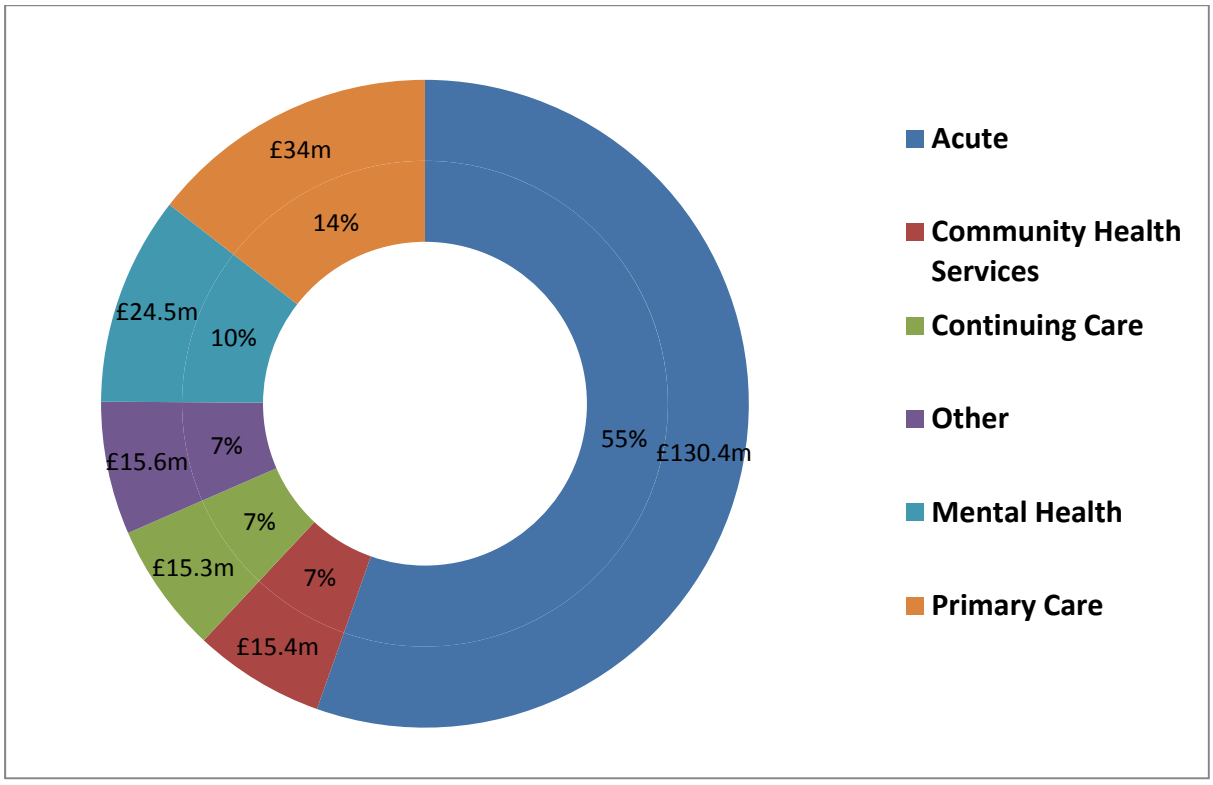
We delivered a planned surplus of £3.7 million (1.5%) against our programme allocation. This will be carried forward to support investments in services in future years.

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

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

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

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

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

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

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

<u>The design and operation of the Assurance Framework and associated processes.</u>

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.

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

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

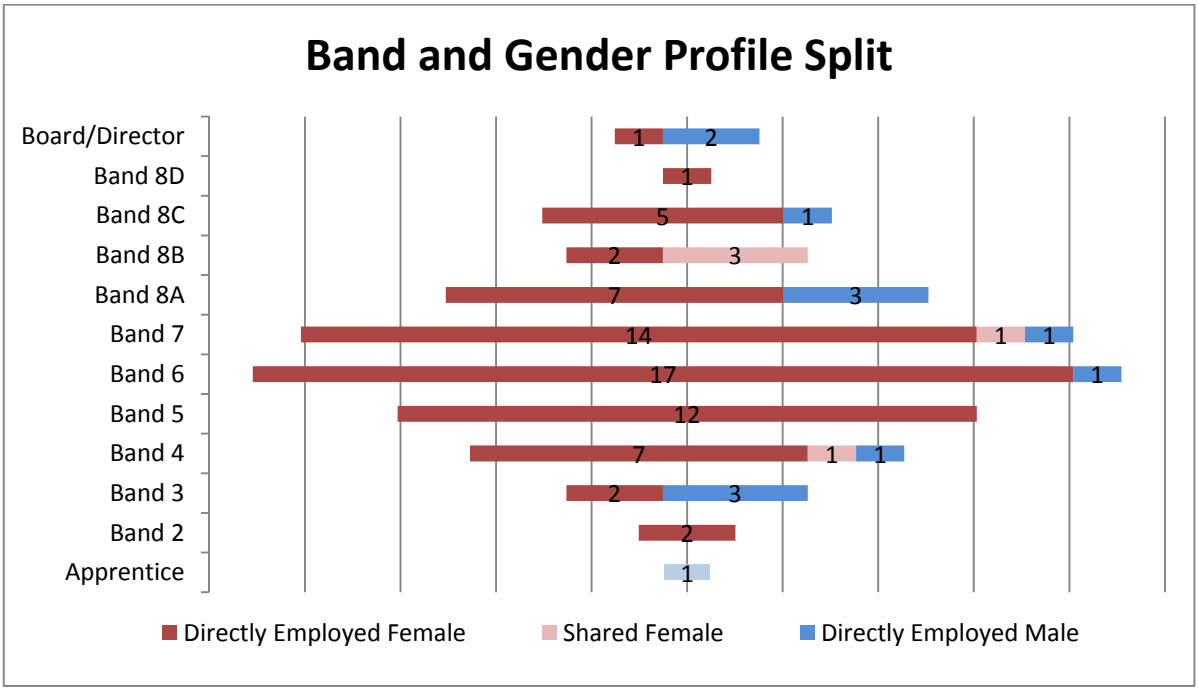
Exit packages and severance payments

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

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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 £000	2014-15 £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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
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)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
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.

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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.

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**

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	Total	Permanent Employees	Other	2014-15 Total
	£000	£000	£000	£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 £000	**Buildings £000**	**Other £000**	**Total £000**	**Land £000**	**Buildings £000**	**Other £000**	**Total £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 £000	**Buildings £000**	**Other £000**	**Total £000**	**Land £000**	**Buildings £000**	**Other £000**	**Total £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 £000	2014-15 £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 £000	2014-15 £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 £000	**2014-15** £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 2015-16 £'000	Payments to Related Party 2014-15 £'000	Amounts owed to Related Party 2015-16 £'000	Amounts owed to Related Party 2014-15 £'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 £000	2014-15 £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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