FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: **29 September 2016**

TITLE OF PAPER: **NHS Greater Huddersfield CCG – Annual Report & Accounts 2015/16**

1. Purpose of paper

CCGs have a statutory duty to produce and publish, as a single document, an Annual Report and Accounts. This document should present the story of the CCG's activities during the previous financial year and the form and content is directed by NHS England. The CCG is further required to present its Annual Report and Accounts to the Health & Well-Being Board.

2. Background

HM Treasury is currently undertaking the Simplification and Streamlining of Accounts project, the aim of which is to 'simplify and streamline the presentation of the Annual Report and Accounts…so as to better meet the needs of the users of the accounts and, where possible, remove unnecessary burdens from the preparer community'. As a result of this, significant changes have been made to the format of CCG Annual Report & Accounts from 2015/16.

Statutory Framework for 2015/16

NHS bodies are required to publish, as a single document, a three part annual report and accounts. This document must include:

- The Performance Report, which should provide information on the CCG, its main objectives and strategies and the principal risks that it faces. This must include an overview summary and information on the CCG's most important performance measures, including performance in relation to sustainable development.
- The Accountability Report, which is designed to meet key accountability requirements to Parliament, and consists of:
  - A Corporate Governance Report
  - A Remuneration and Staff Report
- The Financial Statements

3. Proposal

The purpose of this report is to formally present Greater Huddersfield Clinical Commissioning Group 2015/16 Annual Report and Accounts to the Health & Well-Being Board.

4. Financial Implications

There are no financial implications resulting from this report.
The report contains the CCG's Annual Accounts, which set out the CCG's financial position as at the end of 2015/16.

5. Sign off

Carol McKenna, Chief Officer, Greater Huddersfield CCG (12/9/16)

6. Next Steps

No identified next steps. The Annual Report & Accounts 2015/16 are already available to view on the CCG's website at www.greaterhuddersfieldccg.nhs.uk

7. Recommendations

That the Board **NOTE** the CCG's Annual Report & Accounts 2015/16.

8. Contact Officer

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NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report and Accounts 2015/16

Annual Report – prepared as required under Section 14Z15 of the National Health Service Act 2006 (as amended)

Annual Accounts – prepared as required under Section 17 of Schedule 1A of the National Health Service Act 2006 (as amended)

Contents

Annual Report & Accounts

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

The Annual Report and Accounts consists of three sections:

- **The Performance Report**, which must include:
- **The Accountability Report**, which must include:
- **The Financial Statements**

This is the Annual Report & Accounts 2015/16 for Greater Huddersfield Clinical Commissioning Group, as approved by the Audit Committee in accordance with the Clinical Commissioning Group's Scheme of Delegation, on 18 May 2016.

Carol McKenna **Date: 24 May 2016**
Accountable Officer

Chair's Introduction

This has been another busy year for the CCG with a number of different challenges. We were able to reach our target surplus set by NHS England but we are under no illusion that we are in financial good health. For that reason we have set up a Recovery Group to really focus on cost savings. This work launched in April and will continue throughout 2016/17.

The CCG expanded quite considerably this year with the close down of the Commissioning Support Unit (CSU), when we welcomed a number of new colleagues into the CCG. We chose to 'in-house' a number of services previously provided by the CSU with a view to improving and streamlining our services. This has given our organisation a different feel but it is good to have colleagues working with us and making them feel part of our team.

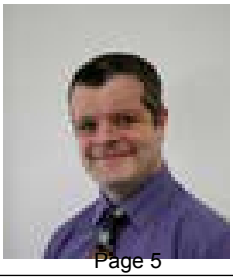
We awarded our Care Closer to Home contract in July, with the new service going live from October. Overall, we have been pleased with the way it has started and look forward to this service really adding value to community services and keeping people out of hospital, when they don't actually need to be there.

We have also launched our public consultation on reconfiguring hospital services. This will continue into 2016/17 and we look forward to listening to people and explaining our proposals. We recognise our system has significant quality, workforce, and financial issues and we need to make changes to the way services are delivered if we are to be able to maintain high quality healthcare for our population. We need to address these issues and this is why we are in consultation.

We have had several Governing Body Members leave this year and have replaced a number of them. This process will continue and we will look to bring fresh faces onto the Governing Body and continue our work serving our population.

So, we recognise the challenges ahead but are determined to keep working hard and succeeding for all our patients in Greater Huddersfield. I hope you find our Annual Report informative and we encourage anyone who has questions to get in touch.

Dr Steve Ollerton
Chair, NHS Greater Huddersfield CCG



NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report 2015/16

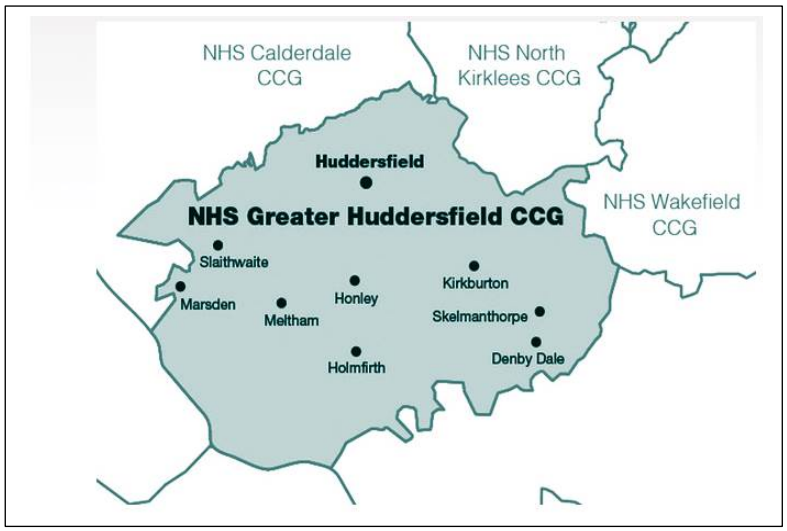
The Performance Report

The Performance Report - Overview

This section of the Annual Report provides our Chief Officer's perspective on the performance of the CCG over the last twelve months. It includes information about the CCG, our main objectives and strategies, the principal risks that we face, and how we have performed during the year.

About Us – Our Purpose and Activities

Greater Huddersfield Clinical Commissioning Group (CCG) is a membership organisation of 38 general practices (37 from 1st April 2016). We are led by local GPs and it is our role to commission (plan and buy) the majority of hospital and community health services for our local population. 243,000 people live in our area (approximately 58% of the Kirklees Council area), and the map shows the area we cover.



It is our responsibility to ensure that the services we commission are high quality, safe and sustainable and that in doing so we manage our budgets efficiently and effectively.

Our Population and Their Needs

Approximately 243,000 people live in Greater Huddersfield, and this is forecast to increase by 13% by 2037, which is consistent with the expected population increase for England of 14%.

As in other parts of the country we are seeing an increase in older people with many more living well into their 80s and 90s. In 2012, 16% of the population was aged 65 and over, and by 2030 this is expected to increase to a quarter of our population. This means more people living longer, often with long term illnesses such as heart disease, diabetes and chronic chest problems and more with dementia. This has a major impact on health and care services as older people are some of the most frequent users of services. They need the right care and support to manage their illnesses, stay as well as possible and be independent in their own homes.

Lifestyle choices have a significant impact on the major causes of ill health and premature death in Greater Huddersfield. Whilst smoking rates continue to decline, there remains significant challenges, especially among women of childbearing age, children and those living in the more deprived areas. 2 in 5 14 year olds live with an adult who smokes. Patterns of alcohol consumption indicate rising levels of risk among adults in the Holme Valley and Denby Dale and Kirkburton. Among teenagers this is most marked in the Colne Valley, Holme Valley and Denby Dale and Kirkburton.

Whilst 1 in 3 adults report achieving the recommended physical activity levels, a significant improvement on 2005, there is still more to be done. 1 in 4 adults exhibit 3 or more unhealthy behaviours; a rising trend, especially in Huddersfield South, where it affects 1 in 3 adults.

There are also inequalities in health across our area with average life expectancy at birth lower than the national average.

The CCG is fully signed up to the Kirklees Joint Health & Well-Being Strategy.

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

Our Vision and Values

The CCG is passionate about making a difference to the health of the people in this area. It has agreed that it will abide by the principles, values and rights clearly set out in the NHS Constitution to make sure that the NHS in Greater Huddersfield works fairly and effectively.

The CCG has also developed its own Vision and Values:

Our Vision:
"Informed by our local population and clinicians, we will drive improvement of healthcare services through leadership, innovation and excellence."

Our Values:

- **Listening** to health professionals, local people and those who support the CCG, in the commissioning of high quality healthcare in the most appropriate setting.
- **Leading** through enthusiasm and cohesiveness to reduce health inequalities in Greater Huddersfield.
- **Enabling** local people and clinicians to transform and improve Greater Huddersfield's health and healthcare.
- **Learning** from other CCGs, service providers, the local authority, and NHS England to inform a strategic long term vision for change.

In May 2016, the CCG launched its new Vision and Values.

Our Strategic Goals and Objectives

In 2013, the CCG set three long term Strategic Goals, underpinned by eleven Strategic Objectives:

Strategic Goals:

- Improving the quality of healthcare services and each individual's experience of care.
- Improving the health of the population.
- Be a high performing CCG and deliver best value by using our resources effectively.

Strategic Objectives:

- Ensuring people have a positive experience of care.
- Ensuring our patients get timely and appropriate access to services.
- Ensuring our providers deliver high quality services.
- Increasing service integration across health, health and social care, primary and secondary care.
- Reducing health inequalities.
- Putting health improvement plans with clearly defined and sustainable quality outcomes into action.
- Reducing inappropriate clinical variation.
- Stimulating innovation and service transformation.
- Balancing budgets at practice and CCG level.
- Delivering our five year Quality Innovation Productivity and Prevention (QIPP) plans.
- Valuing and developing our staff through leadership and training.

In May 2016, the CCG launched its new Strategic Ambitions and Objectives.

Our Commissioning Intentions and Ambitions

Our **Operational Plan for 2016/17** sets out our priorities over the coming years in response to the **Five Year Forward View**[1]. It sets out that the main focus of our work in 2016/17 will be a continuation of the work we started in 2015/16, to continue to commission services that deliver care in a timely way, closer to where people live and, as a consequence, reduce the occasions where hospital admission is required.

We face significant challenges to improve hospital and community health services. In 2014/15, following engagement with patients, carers, the public and local partner organisations, we took the decision to focus initially on our Care Closer to Home model, with the aim of establishing strong community services for our population. We acknowledged that changes to hospital services would need to be made, but that by getting improvements to community services in place first, we would be in a better place during 2015/16 to decide if we were ready to consult on any proposals relating to hospital services.

[1] The Five Year Forward View was published in October 2014 and sets out a shared vision for the future of the NHS based around new models of care. It was developed by partner organisations that deliver and oversee health and care services including the Care Quality Commission, Public Health England and NHS Improvement. It sets out a collective view of how the health service needs to change over the next five years if it is to close the widening gaps in the health of the population, quality of care and the funding of services.

During 2015/16, we therefore prioritised the commissioning of our **Care Closer to Home** service. We worked closely with service users, their families and local organisations to set our aims and ambitions for these services and have undertaken a procurement process to secure the right provider for these services. A new community contract was awarded to Locala Community Partnerships and became operational from 1st October 2015.

Fundamental to this transformation is the role of primary care and GP practices. As a membership organisation, we continue to work with our member practices to help make the changes needed if primary care services in Huddersfield are to be the best that they can be. During 2015/16 we have been revising our **Primary Care Strategy** and the final version was published in April 2016 to coincide with our role in fully delegated primary care commissioning.

The CCG, working with Calderdale CCG, has been developing far reaching proposals during 2015/16 for **hospital services**. These proposed changes would secure the future of health services for both areas for the next 20 years, ensuring that our hospital services are in line with national recommendations and guidance. They will also mean that more services are provided in the community, including some outpatient clinics, so that people only need to go to hospital when they really need to be there.

Our proposed changes will help us address a number of big challenges:

- We don't comply with national guidance – currently the two A&Es at Halifax and Huddersfield do not comply with many of the standards for children and young people in emergency care settings. By providing an intensive care unit at each site, the Trust is not able to fully comply with NHS England's guidance on critical care workforce standards.
- The number of patients dying in our hospitals is higher than average – the Trust's hospitality mortality rates are higher than the England average.
- Too many patients are re-admitted within 30 days – the number of patients who need to come back into our hospitals as emergency readmissions within 30 days of discharge is above the national average.
- Too many patients are admitted to hospital with a long term condition – adults with chronic illnesses in Calderdale and Greater Huddersfield are more likely to be taken into hospital than other patients in England, as are young people with asthma, diabetes and epilepsy.
- Too many patients stay longer in hospital than clinically necessary – our Delayed Transfer of Care rate is over target which means older and vulnerable people spending longer in hospital than they need to while arrangements are made to provide care and support at home or in residential and nursing care homes.
- Too many patients don't have a good experience in our hospitals – more is needed to improve the experience of patients using our hospitals, which have a higher than national average number of complaints.
- In the last 15 years there have been great advances in medical knowledge and technology and the development of increasingly sophisticated and specialist treatments and procedures – we need to make sure our health system has adapted to meet these and future advances so that patients can get the latest treatments and have the best chances of good outcomes when they become very ill.
- A number of hospital services are experiencing serious challenges in recruiting and retaining staff as well as being non-compliant or struggling to meet the Royal College of Emergency Medicine's recommendations.

- The local health economy is facing a very difficult financial situation - without change the system would become financially unstable and would not be able to afford the improvements needed to deliver consistently safe, high quality, sustainable care.

We have looked very closely at the different ways that we could use the two hospitals to address the challenges we face and ensure high quality, safe, sustainable and affordable services going forward. We started by setting out the clinical standards that we need to achieve, and from these identified the outcomes and benefits we could achieve for patients. Clinicians from the hospitals and the CCGs then considered national guidance and delivery models from other areas to develop a potential future clinical model, which described the way that services should be configured to deliver the best outcomes and quality of care for patients. The challenges we face mean that there is only one clinical alternative, which is to have one Emergency Centre site and one planned care site in order to maintain quality and ensure services are safe.

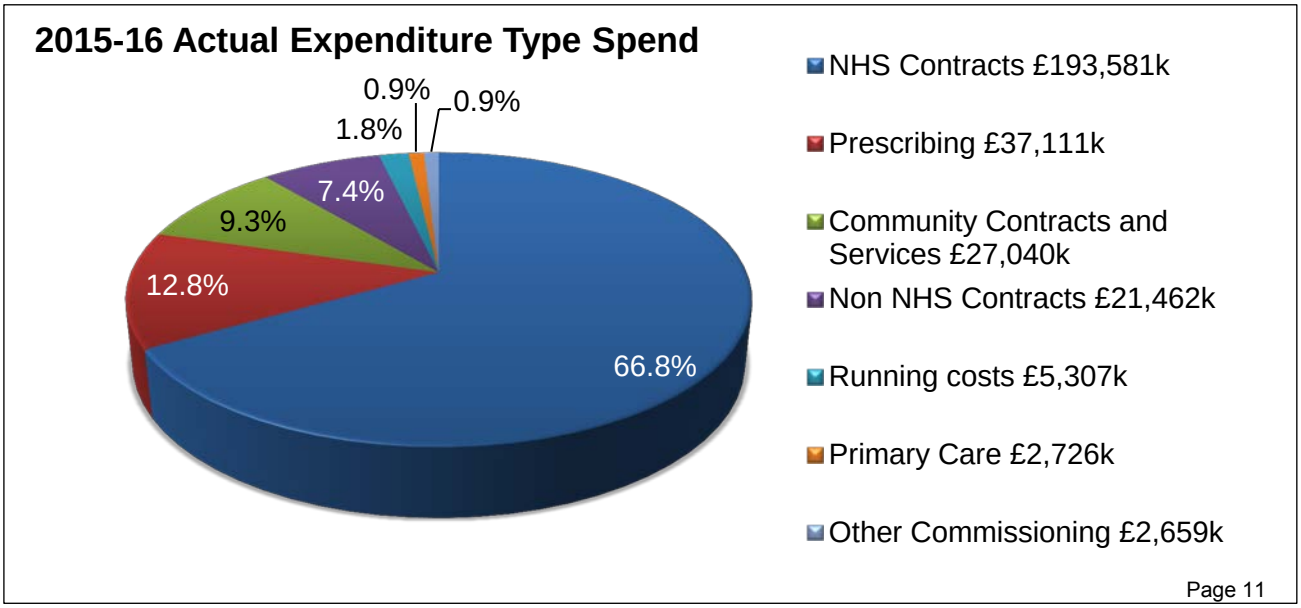
The CCG, in conjunction with Calderdale CCG, is consulting people on the new model for hospital and community health services, across six themes:

- Emergency and Acute Care
- Urgent Care
- Maternity
- Paediatrics
- Planned Care
- Community Health Services

The consultation will conclude on 21 June 2016, and will help the CCGs to understand the views of patients, public stakeholders and staff who live and work in Greater Huddersfield, Calderdale and others for whom the proposed changes may have a direct impact. This is so that by the end of October 2016, both CCGs can make an informed decision on progressing the future shape of hospital services ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients.

Our Financial Position

During 2015/16 we invested over £289m to improve the health of local people through the commissioning of high quality services which is illustrated in the pie-chart and table of numbers below:-



Expenditure Type	£,000	%
NHS Contracts	193,581	66.8%
Prescribing	37,111	12.8%
Community Contracts and Services	27,040	9.3%
Non NHS Contracts	21,462	7.4%
Running costs	5,307	1.8%
Primary Care	2,726	0.9%
Other Commissioning	2,659	0.9%

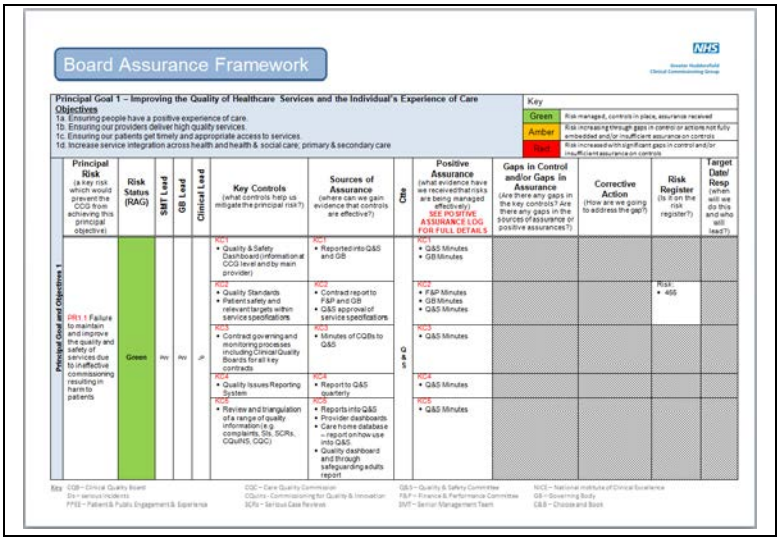
2015-16 Total Expenditure	289,887	100.0%

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

After working closely with our local commissioning partners a £29m Better Care Fund became operational on 1st April 2015 which pools a number of investments across Kirklees for the integration of services for health and social care to provide an improved joined up service for our patients

Key Issues and Risks

The CCG's principal risks are set out within the Board Assurance Framework – this is a Governing Body level assessment of the organisation's objectives and the risks that may prevent or hinder the objectives being achieved. The Framework is important for the Governing Body as it allows the CCG to be confident that the systems, policies and people they have put in place are operating in a way that is effective in delivering the strategic objectives and minimising risks.



The Framework sets out the ways that the CCG seeks to control these risks, and how the Governing Body assures itself that these controls are working. Any gaps in assurance or control are identified and action plans are developed to address them. The Framework is kept under review by the Senior Management Team, Audit Committee and Governing Body as a true and fair reflection of strategic risks, and evidence that satisfactory progress is being maintained to manage risk.

For each of the three CCG strategic goals, the principal risks that would prevent the CCG from achieving these goals are set out within the Board Assurance Framework:

Principal Goal 1 **Improving the Quality of Healthcare Services and the Individual's Experience of Care**
• Failure to maintain and improve the quality and safety of services due to ineffective commissioning resulting in harm to patients
• Risk that commissioning arrangements for safeguarding do not ensure that providers are effectively safeguarding children and adults due to ineffective safeguarding arrangements with partners, resulting in harm to children and adults
• Risk that patients acquire infections while in receipt of commissioned health services due to poor quality service delivery and inappropriate prescribing of antibiotics, resulting in harm to patients
• Risk of not improving and maintaining patient experience due to: not using patient intelligence appropriately with providers to improve that experience; and not using patient intelligence to develop commissioning plans or service specifications; resulting in patient dissatisfaction
• Risk that the CCG does not appropriately consider people with protected characteristics due to lack of effective processes for capturing equality and diversity information resulting in ineffective commissioning decisions and failing to meet statutory duty
• Failure to commission services that deliver effective care and improve outcomes for patients due to: - not implementing evidence based practice - not facilitating service integration across health and social care, and primary and secondary care
• Risk that patients do not access services due to ineffective communications resulting in patients not getting timely and appropriate access to services.
Principal Goal 2 **Improving the Health of the Population**
• Inadequate engagement with local authority, other CCGs, providers, practices and stakeholders leading to inadequate health influence in the district.
• Risk that the CCG fails to reduce health inequalities due to a lack of appropriate and timely needs information
• Risk that the CCG implements health improvement plans without being able to demonstrate the benefits of these, due to not measuring improvement, resulting in inappropriate commissioning decisions
Principal Goal 3 **Be a high performing CCG and deliver best value using our resources effectively**
• Risk of pressure on the Medium Term Financial Plan due to uncertainty of future national planning guidance for 2015/16 (e.g. Continuing Healthcare, Co-Commissioning, Specialised Commissioning, Better Care Fund) resulting in unforeseen financial risk
• Long term financial risk that demand for services increases at a level above annual uplift due to: CCG not reducing reliance on unplanned hospital based care; patient choice; increasing patient expectations; resulting in an affordability gap
• Risk that fail to fulfil our statutory responsibilities and duties due to a lack of robust governance arrangements
• Risk that innovative service transformation is stifled due to: Finance; Development of workforce to deliver innovative services; Engagement with public and patients; Engagement and communication with key stakeholders.
• Risk to CCG as a membership organisation due to member practices not engaging or supporting the CCG resulting in failure to operate within the NHS Constitution
• Risk of inappropriate clinical variation due to failure to address the quality, efficiency and access to general practice
• Risk that do not value and develop our staff due to insufficient investment (time / resource / money)

Financial Risk

There are a number of risks that threaten delivery of our 2016/17 financial plan, these include:

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

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

- Investments are only deployed if there is robust assurance that they are affordable;
- Effective processes identify and realise opportunities for disinvestment and reinvestment in healthcare, to improve outcomes and ensure the money is directed where it can do most good; and
- We continue to adopt a collaborative approach with partners to ensure that resources are deployed effectively.
- We have established robust QIPP management processes which are supported by senior clinicians and managers and an additional lay member to focus on QIPP specifically.

Performance Summary

The Annual Report this year highlights a number of areas where NHS Constitution targets continue to have been met and identifies those that remain a challenge in Greater Huddersfield CCG.

Demand on our hospital services has been particularly challenging this past year as our population ages and emergency admissions increase. Our health economy has experienced considerable challenges, not least for A&E and the urgent care system. This has had implications for wait times, notably the number of patients waiting over four hours in A&E.

We have been working closely with system leaders and the NHSE area team to put plans in place where performance has not met national targets and we are working together to transform services and future commissioning to ensure all indicators are achieved.

More detailed information on our performance is set out on the following pages.

The Performance Report – Performance Analysis

This section of the Annual Report provides a more detailed performance analysis, and reports on key performance measures and how the CCG checks itself against them.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it.

The Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. The Secretary of State for Health, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required by law to take account of this Constitution in their decisions and actions.

Principles that guide the NHS

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism.
4. The patient will be at the heart of everything the NHS does.
5. The NHS works across organisational boundaries.
6. The NHS is committed to providing best value for taxpayers' money.
7. The NHS is accountable to the public, communities and patients that it serves.

How the CCG Measures Performance

In order to measure how well the CCG is performing against the NHS Constitutional standards, a monthly performance report is produced showing the current month's performance against each of the metrics as well as the year to date position. Each measure is rated red, amber or green (RAG rated) on both the month and year to date performance using the tolerance set out in the technical definitions. The direction of travel is highlighted which indicates whether performance is improving or declining from one month to the next.

Initial scrutiny on the CCG's performance is sought by the Finance & Performance Committee, via the performance report which is reviewed monthly and includes updates on health economy-wide system issues, portfolio specific updates including risk, in addition to progress against NHS Constitution pledges.

The Governing Body receives a performance dashboard that details performance against key quality standards, the NHS Constitution pledges, progress against the NHS Outcomes Framework and deliverables such as dementia diagnosis and increased access to psychological therapies (IAPT) bi monthly. Any indicator not achieving the national standard is reported by exception to the Governing Body detailing the reasons for underperformance and actions taken to address it. Any prolonged underperformance is addressed by a performance improvement plan which is monitored throughout the recovery period.

The underperformance of services commissioned by the CCG and/or constitutional standards is addressed by the appropriate contract management group through monthly meetings. Greater Huddersfield CCG is the lead commissioner for Calderdale and Huddersfield Foundation Trust. The Trust produces a monthly Service Quality and Performance Report (SQPR) which identifies performance against the constitutional standards and key performance indicators monitoring the delivery of services. The SQPR gives both a trust/provider view and how that disaggregates for the commissioners/CCGs.

The performance is discussed monthly though arrangements set up by the Partnership Steering Group (PSG), chaired by the CCG Head of Contracting and Procurement and focuses on Planned Care, Urgent and Emergency Care, Children and Young People and Community Services. Any service issues are highlighted and actions taken to address the underperformance are agreed. Where appropriate, a remedial action plan is put in place and monitored until recovered. Any further deterioration of performance or milestones not achieved within the recovery timescales may incur a penalty.

Greater Huddersfield CCG is also the lead commissioner for the Community Services contract provided by Locala across Kirklees. A monthly Performance and Quality Dashboard is produced ahead of the contracting meeting and areas of underperformance against constitutional standards and/or patient outcomes are addressed at the meeting.

The outputs from the contracting meetings feed into the performance and contracting reports which are then presented to the Finance & Performance Committee and the Governing Body.

Assurance

NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The CCG assurance framework for 2015/16 sets out five components that reflect the key elements of a well led effective clinical commissioner and underpin assurance discussions between CCGs and NHS England, whilst identifying on-going ambitions for CCG development. The components include being well led; performance; financial management; planning; and delegated functions.

The CCG has quarterly assurance checkpoint meetings with NHS England which includes assurance against quality key performance indicators, NHS Constitution pledges, progress against NHS Outcomes Framework and financial scrutiny.

In addition, we are asked to provide regular evidence against the following six domains:

- **Domain 1**: Are patients receiving clinically commissioned, high-quality services?
- **Domain 2**: Are patients and the public actively engaged and involved?
- **Domain 3**: Are CCG plans delivering better outcomes for patients?
- **Domain 4**: Does the CCG have robust governance arrangements?
- **Domain 5**: Are CCGs working in partnership with others?
- **Domain 6**: Does the CCG have strong and robust leadership?

The CCG assurance processes are designed to provide confidence to internal and external stakeholders and the wider public that the CCG is operating effectively to commission safe, high-quality and sustainable services within our resources. Where issues are identified, clear action plans and monitoring are put into place.

The CCG had its annual assurance meeting with NHS England on 29 April 2016; at the time of writing, the CCG had not received formal notification of the outcome of this assurance meeting.

Further Detail on the CCG's Development and Performance

Referral to Treatment (RTT)

The NHS Constitution states that patients have the right to access certain services commissioned by the CCG within maximum waiting times.

The operational standard is that 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral to treatment. This allows for situations where patients choose to delay appointments, cases where patients do not attend appointments, and cases where clinically-based exceptions are needed.

In Greater Huddersfield CCG we have consistently achieved the 18 week standard for incomplete pathways throughout the year, at both aggregate and specialty level. The year to date performance as at February 2016 (month 11) was 95.2%

Number of patients waiting more than 52 weeks

In 2013/14, NHS England introduced a 'zero tolerance' policy for any referral to treatment waits of more than 52 weeks, with such waits resulting in contractual penalties.

As at February 2016 (month 11), no Greater Huddersfield CCG residents had waited 52 weeks or more.

Diagnostic test wait times

Prompt access to diagnostic tests is a key supporting measure for the delivery of the referral to treatment maximum waiting time standards. Early diagnosis is also important for patients and central to improving outcomes, for example, early diagnosis of cancer improves survival rates.

The operational standard is that the percentage of patients waiting 6 weeks or more for a diagnostic test should be less than 1%.

In Greater Huddersfield CCG, the waiting times standard was achieved in 9 out of 11 months throughout the year, with performance as at the end of February 2016 (month 11) of 0.5%. Where this was not achieved, this was due to there being insufficient capacity through mobile scanning units. This was subsequently rectified through tighter management of the booking process and additional clinics to manage increased demand, largely linked to cancer screening campaigns. The Trust has secured an additional scanner that will be in operation from July 2016.

Accident and emergency waits – total time in the A&E department

The NHS Constitution states that patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department.

Longer lengths of stay are associated with poorer health outcomes and patient experience, as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen and financial effects. It is critical that patients receive the care they need in a timely fashion so that patients who require admission are placed in a bed as soon as possible, patients who need to be transferred to other healthcare providers receive transport with minimal delays and patients who are fit to go home are discharged safely and rapidly.

There is professional agreement that some patients need prolonged times in A&E. However, these exceptions are rare and unlikely to account for more than 5% of attendances. The standard is therefore that 95% of patients should be seen within 4 hours.

As at February 2016 (month 11), the performance for Greater Huddersfield CCG was 94.3%. There have been pressures on the urgent care system throughout the year and the System Resilience Group implemented weekly calls throughout winter, improved discipline in escalation, and improved understanding of issues. System resilience funding was invested in 7 day/week services, prevention (Hospital Avoidance Team and 24 hour Mobile Response Unit) and Practice Discharge Co-ordinators. The Trust has invested in additional senior staff in A&E. The NHS Improvement Board has requested a trajectory from the Trust in relation to expected performance in 2016/17, which will need to be agreed with commissioners and monitored throughout the year.

Cancer waits – 14 days

The NHS Constitution states that patients should have a maximum two-week wait for their first outpatient appointment if referred urgently with suspected cancer by a GP. It also states that patients should have a maximum two-week wait for their first outpatient appointment if referred urgently with breast symptoms (where cancer was not initially suspected).

The two-week wait services ensure fast access to diagnostic tests, supporting the provision of an earlier diagnosis and assisting in improving survival rates for cancer.

The standard is that 93% of patients should have a maximum two-week wait for their first outpatient appointment if referred with suspected cancer by a GP or if referred urgently with breast symptoms (where cancer is not initially suspected).

As at the end of February 2016 (month 11), Greater Huddersfield CCG performance was:

- All cancer two-week waits – 97.1%
- Two-week wait for breast symptoms – 95.5%

Performance can be impacted on, in part, by patient choice and the CCG is targeting education for primary care and patients to reduce breaches due to choice.

Cancer waits – 31 and 62 days

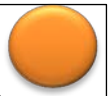
The NHS Constitution sets a number of further standards for cancer waits, to ensure that cancer patients receive all treatments within their package of care within clinically appropriate timeframes, to provide better patient-centred care and improve cancer outcomes.

The standards, and Greater Huddersfield CCG performance as at February 2016 (month 11), are as follows:

- Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – 96% **(CCG performance – 99.4%)**
- Maximum 31 day wait for subsequent treatment where that treatment is surgery – 94% **(CCG performance – 97.9%)**
- Maximum 31 days wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% **(CCG performance – 99.7%)**
- Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% **(CCG performance – 99.7%)**
- Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer – 85% **(CCG performance – 88.2%)**
- Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% **(CCG performance – 98.8%)**
- Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority – there is no current operational standard, however performance data is monitored and published as national statistics. **(CCG performance – 85.7%)**

Performance is strong but can be greatly impacted by minimum breaches due to the low number of patients on the pathway. All breaches have a root cause analysis undertaken and breach reasons are monitored monthly.

Mixed Sex Accommodation (MSA) breaches



All providers of NHS funded care are expected to eliminate mixed sex accommodation, except where it is in the overall best interest of the patient. All organisations are held to account for managing beds and facilities to eliminate MSA, and sanctions are applied by commissioners to organisations that breach the standard. We know that MSA is distressing for patients at a time when they feel at their most vulnerable.

As at the end of February 2016 (month 11), there have been two incidents of MSA at Calderdale & Huddersfield Foundation Trust on the Huddersfield Royal Infirmary site involving three Greater Huddersfield CCG patients. Following any reports of MSA, a root cause analysis is undertaken, learning is shared throughout the Trust, and processes are put in place to mitigate any reoccurrence.

Category A ambulance calls: (Red 1) 8 minute response time; (Red 2) 8 minute response time

The NHS Constitution sets a number of standards for ambulance response times in respect of conditions that may be life threatening.

There are two key standards:

- Category A Red 1 Incidents – presenting conditions that may be immediately life-threatening and the most time critical, and should receive an emergency response within 8 minutes irrespective of location, in 75% of cases.
- Category A Red 2 Incidents – presenting conditions that may be life threatening but less time critical than Red 1 and should receive an emergency response within 8 minutes irrespective of location, in 75% of cases.

As at the end of February 2016, Greater Huddersfield CCG performance was:

- Category A Red 1 incidents – 76.1% *(in 2014/15, performance was 72.7%)*
- Category A Red 2 incidents – 71.4% *(in 2014/15, performance was 65.8%)*

This service is commissioned regionally and presents challenges in rural areas. Yorkshire Ambulance Service has been invited by NHS England to take part in Phase 2 of the Ambulance Response Programme (ARP), which has seen NHS England undertake a clinical review of the ambulance response codes, creating three new response categories. This pilot will run for 3 months from 21 April 2016.

Requests for ambulance transport can vary from immediately life-threatening cases to routine transfers of care. In order to ensure the right response is provided at the right time, depending on the patient's presenting condition, YAS have produced an algorithm and advice sheet to help GPs and Health Care Practitioners when requesting an ambulance response.

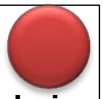
Healthcare Acquired Infections (HCAI) measure (MRSA)

Tackling preventable healthcare associated infections, such as MRSA bloodstream infections, is one of the NHS's key priorities.

With reported MRSA bloodstream infections at an all-time low and many trusts reporting zero cases of MRSA bloodstream infection over the past year, the CCG is clear that preventable MRSA bloodstream infections are not acceptable in NHS funded services. There is a zero tolerance standard.

There has been one reported case of MRSA at Calderdale & Huddersfield NHS Foundation Trust in 2015/16. Any reported cases of MRSA are investigated by the Trust and the Head of Health Protection to identify the root cause and to understand if the incident was avoidable. If a case is deemed avoidable, process and procedures will be put in place to mitigate the risk of any further incidents. The details of the root cause analysis are shared with the Quality & Safety Committee and action plans agreed to monitor performance throughout the year are scrutinised by the Quality Team.

Healthcare Acquired Infections (HCAI) measure (Clostridium Difficile infections)



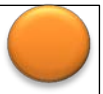
CDI is an unpleasant and potentially severe or fatal infections that occurs mainly in elderly and other vulnerable patient groups, especially those who have been exposed to antibiotic treatment.

The 2015/16 annual CDI objectives for the CCG were set at no more than 40 cases. The CCG is required to establish and report against monthly trajectories for CDI cases in order to ensure continued reduction.

There have been 41 reported cases in Greater Huddersfield as at the end of February 2016 (month 11). Any reported cases of CDI are investigated and the Head of Health Protection to identify the root cause and to understand if the incident was avoidable. If a case is deemed avoidable, process and procedures will be put in place to mitigate the risk of any further incidents. The details of the root cause analysis are shared with the Quality & Safety Committee and action plans agreed to monitor performance throughout the year are scrutinised by the Quality Team.

As a result of the number of reported cases of CDI exceeding the objective set for both the CCG and our neighbouring CCGs, a summit was held at Mid Yorkshire Hospital Trust. The learning from the summit will be used to inform a Calderdale & Huddersfield NHS Foundation Trust summit in late summer 2016.

Cancelled Operations



All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons must be offered another binding date within 28 days or the patient's treatment should be funded at the time and hospital of the patient's choice.

As at February 2016 (month 11), there was 1 reported breach of the Cancelled Operations standard at Calderdale & Huddersfield NHS Foundation Trust. The standard is monitored closely via the Contracting Group, where assurance has been received that processes are in place to ensure that the standard is not breached again.

Mental health measure – Care Programme Approach (CPA)

The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

This standard relates to the proportion of those patients on CPA discharged from inpatient care who are followed up within 7 days, and at least 95% of patients must be followed up after discharge each quarter.

As at the end of Quarter 3, Greater Huddersfield CCG had achieved 98.6%.

NHS Constitution

The dashboard over the next two pages shows performance against all NHS constitutional measures, for both the current month and year to date. Out of the 24 indicators in the NHS Constitution, 17 indictors are green, 2 amber and 5 red.

Reporting Period Feb 2015/16

NHS Constitution Rights and Pledges 2015/16

Outcome/Measure		Target/ Baseline	Period Actual	Period RAGS	YTD	YTD RAG	Direction of Travel
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	-	85.7%		86.1%		
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	-	97.3%		97.3%		
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	94.7%		95.2%		
	Number of patients waiting more than 52 weeks	0	0		0		
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	99.5%		99.5%		
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	89.4%		94.3%		
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0		0		
Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with	93%	99.2%		97.1%		
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	95.8%		95.5%		
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	100.0%		99.4%		
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100.0%		97.9%		
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100.0%		99.7%		
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100.0%		99.7%		

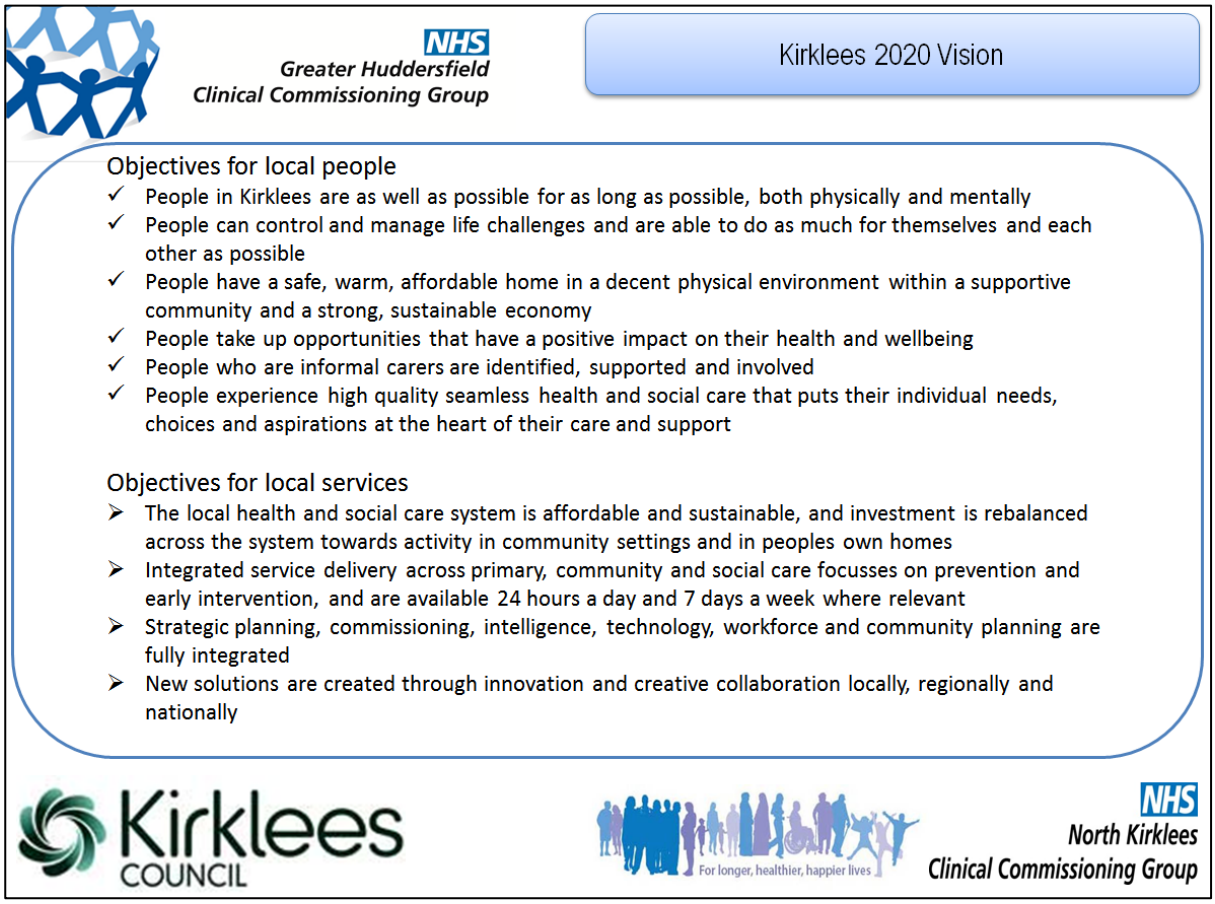
Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	88.2%		88.2%		↑
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%		98.8%		↔
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	-	100.0%		85.7%		↔
Category A Ambulance Calls	Category A calls resulting in an emergency response arriving within 8 minutes (Red 1)	75%	79.7%		76.1%		↑
	Category A calls resulting in an emergency response arriving within 8 minutes (Red 2)	75%	73.2%		71.4%		↑
	Category A calls resulting in an ambulance arriving at the scene within 19 minutes	95%	97.8%		96.5%		↑
	All handovers between ambulance and A&E must take place within 15 minutes	95%	78.7%		85.5%		↓
	All crews should be ready to accept new calls within a further 15 minutes	95%	72.4%		75.2%		↑
Mixed Sex Accommodation	Minimise breaches	0	0		3		↓
MRSA	Number of MRSA reported infections	0	0		1		↔
C_Diff	Number of C-Diff blood stream infections	40	5		41		↑
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days	0	Q3 1		1		↔
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge	95%	Q3 99.1%		98.6%		↔

Better Care Fund

The Better Care Fund was announced by the Government in the June 2013 spending round, to ensure a transformation in integrated health and social care. The Better Care Fund (BCF) is one of the most ambitious ever programmes across the NHS and Local Government. It creates a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The Better Care Fund is governed by the Kirklees Health and Wellbeing Board and comprises of three organisations, North Kirklees CCG, Greater Huddersfield CCG and Kirklees Council.

The Joint Health & Well-Being Strategy (JHWS) recognises that whilst there have been overall improvements in local health and wellbeing there are still significant health and care challenges set out in the Joint Strategic Needs Assessment (JSNA). The most recent refresh of the JHWS has sharpened the focus on creating an integrated health and social care system that is capable to responding to these challenges. The Health and Wellbeing Board is leading the development of the Kirklees Sustainability and Transformation Plan. The draft objectives are shown in the diagram below:



The overall population outcome we are aiming to achieve through the BCF plan is:

"People with health and social care needs feel supported and in control of their condition and care, enjoying independence for longer."

This overall outcome is underpinned by four specific person centred outcomes:

- People who need support are in control of high quality, personalised support in their own home or community that enables them to stay safe, healthy and well for as long as is possible.
- People who need care that can only be provided in a specialist setting are admitted and receive good quality specialist care only for as long as is clinically necessary.
- People who have received care regain, as far as possible, their skills, abilities and independence through enhanced reablement and rehabilitation support.
- People with ongoing support needs manage their condition/needs as well as possible.

The key performance measures we will use to measure our progress are:

1. **Non-elective admissions** – we will monitor the number of non-elective admissions (emergency admissions) where patients are admitted to hospital. A reduction in the number of emergency admissions is expected as a result of the services in place to avoid a patient being unexpectedly admitted to hospital.
2. **Permanent admissions of older people (65 and over) to residential and nursing care homes** – avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation. The outcome expected is to reduce inappropriate admissions of older people (65+) in to residential care.
3. **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** – the proportion of older people aged 65 or over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital. The outcome expected is to increase the effectiveness of the services whilst ensuring that those offered a service does not decrease. Improving the effectiveness of these services is a good measure of delaying dependency, the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
4. **Delayed transfers of care from hospital (DToC)** – minimising delayed transfer of care and enabling people to live independently at home is one of the desired outcomes of social care. The focus is to identify patients who are in the wrong care setting for their current level of need and it includes patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay. A patient is ready for transfer when:
   (a) A clinical decision has been made that patient is ready for transfer AND
   (b) A multi-disciplinary team decision has been made that patient is ready for transfer AND
   (c) The patient is safe to discharge/transfer.
   We will monitor the number of delayed transfers; the expectation is that the number will reduce.

5. **Dementia diagnosis** - Improving the ability of people living with dementia to cope with symptoms, access to treatment and care and support. The planning guidance states that the national dementia diagnosis rate to two thirds (66.7%) should be achieved and sustained through 2016/17. A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes. The outcome expected is that we maintain the 66.7% standard.
6. **Patient / service User Experience Everyone Involved in my Care knows my Story**: (i) Improvement in response rate on completion of care episode, (ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer. As this is a new measure there is currently no baseline data.

Each of the specific schemes within the Better Care Fund has been selected on the basis of their contribution to delivering these outcomes, their strategic fit and their impact on our key performance measures.

Over the next 5 years primary, community and social care teams will be commissioned to work together in an increasingly integrated way, with co-ordinated, holistic assessments and rapid and effective joint responses to identified needs, provided in and around the person's home and community. By improving the way we work with people to manage their conditions, we will reduce the demand not just on acute hospital services but also on nursing and residential care.

In 2016/17 the BCF will be used to build on the joint work already taking place using within the 9 schemes that form part of our overall strategy to deliver these changes:

1. Preventative Services

- continuing to invest in community based prevention and early intervention activities delivered by voluntary and community organisations that support people with their health and social care needs
- building on Kirklees' track record as a leader in self-care, including the development of an innovative web based 'hub' which will transform the way self-care information, support and resources are accessible to a wide range of people
- continuing to support specialist alcohol nurses working in hospitals to reduce alcohol related admissions and repeat presentations for health and care services.
- providing people with long-term conditions who are at risk of hospital admission or needing additional care services with short term support to build their confidence to manage their needs at home

2. Intermediate care (including Reablement Services, Bed Based Intermediate Care Services, Mobile Response Services)

- enhancing investing in and redesigning community based domiciliary services to support admission avoidance and hospital discharge arrangements and integrated crisis and rapid response services to avoid unplanned admission to secondary care services.
- investing in and redesigning where necessary our community bed base to facilitate early supported discharge and/or reduce need for admission to hospital if care can be provided closer to home. This includes additional investment in palliative and end of life care services.

3. Aids to daily living

- our new Integrated Community Equipment Service went live in April 2014, and will work alongside activity on undertaking minor adaptations to property to ensure people are able to stay in their own homes as long as possible

4. Carers Support Services

- investing in carer related support including respite care/short break activity and specified schemes for dementia related care etc.

5. Additional Community Health Services

- Additional investments into Care Closer to Home services enabling patients to remain within their own homes for as long as possible and facilitate their return to their own home as soon as possible should they be admitted to hospital.

6. End of Life

- increasing access to specialist high quality, responsive and holistic service palliative and end of life care for individuals, their carers and families to support personal preferences.

7. Psychiatric Liaison Services

- ensuring adults experiencing mental health problems who attend the acute hospitals are sign-posted to the most appropriate care; receive parity of care for physical and mental health needs; are not admitted into hospital just to avoid breaching the emergency care target; and receive on-going psychiatric assessment so that they are ready to be discharged once medically fit.

8. Protecting Social Care

- Ensuring that those people with social care eligible needs can receive the care and support they need to maintain or regain their independence and reduce the risk of hospital admission, recognising that as more people have receive care out-of-hospital they will need additional social care support
- Implementing the Care Act, including the predicted increased volumes of assessments, carers assessment and associated packages of care

By offering integrated high quality services at times required to meet the needs of the community Kirklees wishes to reduce reactive, unplanned care and do more planned care earlier. The benefits that patients and their carers will see as a result of the changes and how these will impact on emergency attendances and hospital admissions. People will receive care which is more timely and organised to meet their specific needs. The services they need will be co-ordinated across providers where necessary; ensuring care is co-ordinated and seamless as one coherent package with a focus on helping recovery and promoting independence.

In 2015/16 the payment for performance was linked to a reduction in non-elective emergency admissions. A challenging target was set to reduce admissions by 3.5% from the 2014/15 baseline. Overall for Kirklees, this was achieved in quarters 1 and 3 at an aggregate level, however the variance between commissioners was significant and Greater Huddersfield experienced an increase in non-elective admissions and resulted in significant financial

pressures due to managing a live Payment by Rresults (PbR) contract with our main acute provider CHFT.

Other key performance indicators measured to monitor overall performance were:

Permanent admissions of older people (65 and over) to residential and nursing care homes
Kirklees Performance:
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
Kirklees Performance:
Delayed transfers of care from hospital
Kirklees Performance:
Dementia diagnosis
Kirklees Performance:

Sustainability and Transformation Plan (STPs)

The National NHS Planning Guidance for 2016/17 mandates that systems, inclusive of commissioners, providers and Local Authorities come together over a defined footprint to develop a Sustainability and Transformation Plan (STP).

Since the guidance was released, a number of discussions have taken place at both a local and regional level to determine what footprints should be in place across West Yorkshire. It has been agreed that to ensure local priorities are reflected in the plans, primary STPs will be written at a Health and Wellbeing Board level and feed into an overarching secondary STP which will be developed at a West Yorkshire level by the Health Futures Board.
For our local area the primary STP will be developed over a Kirklees footprint, recognising the complexities of the geography we work within and the interdependencies to neighbouring STP's in Calderdale and Wakefield.

The diagram below shows the primary STPs identified in West Yorkshire:

The STP, both primary and secondary, must address **3 national challenges**: to help set ambitions for local populations;

A. How will you close the health and wellbeing gap?
B. How will you drive transformation to close the care and quality gap?
C. How will you close the finance and efficiency gap?

In addition to these challenges there are also **9 'must do's'** for 2016/17

1. Develop a **high quality and agreed STP** to achieve the triple aim
2. Return the system to **aggregate financial balance**
3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues
4. Get back on track with **access standards for A&E and ambulance waits**
5. Improvement against **18 week RTT target** (92%) including offering choice
6. Deliver **62 day cancer waiting standard**, continue to deliver the **two week and 31 day cancer standards** and make progress in improving **one-year survival rates**
7. Achieve and maintain the **two new mental health access standards** and continue to meet a **dementia diagnosis rate** of at least two-thirds of the estimated number of people with dementia.
8. Deliver actions set out in local plans to **transform care for people with learning disabilities**
9. Develop and implement an **affordable plan to make improvements in quality** particularly for organisations in special measures

And **10 big questions** to answer:

1. How are you going to prevent ill health and moderate demand for healthcare?
2. How are you engaging patients, communities and NHS staff?
3. How will you support, invest in and improve general practice?
4. How will you implement new care models that address local challenges?
5. How will you achieve and maintain performance against core standards?
6. How will you achieve our 2020 ambitions on key clinical priorities?
7. How will you improve quality and safety?
8. How will you deploy technology to accelerate change?
9. How will you develop the workforce you need to deliver change?
10. How will you achieve and maintain financial balance?

Kirklees STP

- Kirklees Health and Wellbeing Board (KHWBB) will be accountable for the Kirklees STP (KSTP), already having a well-established Governance Structure to facilitate decision making and rapid progress.
- KHWBB is represented by both commissioners and providers who have been identified as stakeholders for the KSTP.
- Carol McKenna, Chief Officer of Greater Huddersfield CCG, is the nominated Lead with support from the business planning leads at both CCGs.
- We have identified a nominated senior Lead from each provider organisation.
- We have identified Clinical Leadership from each organisation.

- Some of the provider organisations identified as stakeholders in the Kirklees STP are part of an 'Integration Board'. This includes SWYPFT, LA & Locala and covers strategic developments as well as developing integrated working.

The STP will be produced over the coming months with a deadline for submission to NHS England by 30th June 2016.

Business Intelligence

Yorkshire and Humber Commissioning Support (YHCS) provided Greater Huddersfield CCG with a business intelligence service in 2015/16 but failed to get on the Commissioning Support Lead Provider Framework (LPF) to provide a full range of 'end-to-end' support services. A large scale procurement process was undertaken in 2015 by NHS England with the support CCG's to identify a new provider.

eMBED Health Consortium was awarded the contract and began the delivery of ICT, business intelligence, procurement and other services to 23 Clinical Commissioning Groups (CCGs) in the Yorkshire and Humber region and NHS England from Friday 1 April 2016.

The Consortium will provide a business intelligence service over the next four years to support Greater Huddersfield CCG. eMBED is led by Kier and run in partnership with Dr Foster, BDO and Engine. The eMBED team combines partners who each bring longstanding public and health sector experience and a range of specialist skills. Together they have an outstanding track record and are market leaders in their respective fields of expertise, within the health sector and beyond. The support eMBED provides will be custom-made to match the specific needs of the CCG, with a focus on enabling CCG's to improve quality, cut costs and lead change. eMBED will work with CCGs and other customers to enhance service delivery during the lifetime of the contract.

Financial Performance

The key financial targets we planned to deliver in 2015/16 and we are planning to deliver in 2016/17 are summarised below:

2015/16	2016/17
Planned surplus - £2.9million	Planned break-even
Creation of the Better Care Fund	Responsibility for Primary Care Budgets
Delivery of our QIPP target (£5.5million)	Delivery of our QIPP target (£8.5million)
Allocation in – 1.7% increase	Allocation in – 3.05% increase

In terms of expenditure, the plans include a number of assumptions:

- ✓ That planning requirements set out in "Delivering the Forward View" planning guidance are delivered;
- ✓ That all current recurrent budgets continue to be funded unless we know of plans to change expenditure;

- ✓ That tariff and inflation assumptions are included in line with Monitor guidance;
- ✓ That there will be a 1.0% demographic growth increase on our main contracts; and
- ✓ That all recurrent budget overspends are funded and any under spends released.

In order that we continue to deliver the transformational and service change set out in our strategic plan, a number of Investment Funds have been created within our financial plan for 2016/17, these include:

- Better Care Fund £14.7m
- Non Recurrent 1.0% pot
- Contingency 0.5% pot

Financial Duties

Financial Duty	Achieved/Not Achieved	Performance in 2015/16
Achieve operational financial balance	**Achieved**	Delivered surplus of £2,938k
Maintain capital expenditure within Capital Resources	**Achieved**	Utilised capital resource limit of £39k
Manage cash within the CCG's Cash Limit	**Achieved**	Cash balance of £30k
Public Sector Payment Policy - payment of 95% of invoices within 30 days of the invoice date or goods received if this is later (non-statutory duty)	**Achieved**	Non-NHS invoices 96.3% volume, 99.8% value. NHS invoices 98.1% volume, 99.0% value.

The Performance Report – Sustainability Report

In this section of the Annual Report, we set out the CCG's performance in relation to sustainable development.

"Sustainable development is development that meets the needs of the present, without compromising the ability of future generations to meet their own needs."

(The Brundtland Commission, United Nations – Our Common Future, 1987)

Foreword by Julie Lawreniuk, CCG Sustainability Lead

The CCG remains committed to developing sustainable working practices within our role to commission healthcare services for the 243,000 people who live in our area. Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our footprint.

2015/16 has seen the CCG take significant steps including improving the CCG's Good Corporate Citizen score to 46%, which reflects the work we have put into achieving our sustainability objectives.

In this Sustainability Report we have set out some of the key achievements during the last 12 months, and have shared our objectives and targets for the next year.

Introduction

As part of the 2013 authorisation process, CCGs self-certified compliance with the following statement:

"We declare that at the point of authorisation our CCG will demonstrate commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner."

As a part of the NHS, public health and social care system, it is our duty to contribute towards the ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. Throughout this report, we have set out our carbon reduction targets, including explaining our baseline year.

We have based our report around the eight modules and measures of success developed by the Sustainable Development Unit to deliver the national Sustainable Development Strategy.

About the CCG

The CCG is a membership organisation of 38 general practices (37 from 1 April 2016). Its work is led by senior clinicians across the healthcare system and is based on principles of collaboration and partnership between commissioners, providers and the public. The CCG is responsible for commissioning the health care services for the 243,000 people who live in our area (approximately 58% of the Kirklees Local Authority area).

The CCG's Headquarters are based at Broad Lea House in Huddersfield. Broad Lea House was built to be environmentally friendly from the global, local, external and internal aspects and to minimise the impact on the local community. The development was designed and constructed so as to obtain a BREEAM rating of 'Very Good'.

What is Sustainable Development?

'Sustainable development' is often partnered with good corporate citizenship and used interchangeably with the term 'corporate social responsibility'. Sustainable development and carbon management are corporate responsibilities.

The Sustainable Development Unit, which is jointly funded by NHS England and Public Health England, works on behalf of the health and care system in England, to provide expert advice and support to organisations to help them become more sustainable environmentally, financially and socially. The SDU envisages that organisations in the health system can use their corporate powers and resources in ways that benefit rather than damage the economic, social and physical environment in which we live.

The health system is committed to reducing its carbon emissions in line with the UK Climate Change Act. To help the health system achieve this ambition, organisations are steered by a series of statutory, regulatory and policy requirements as well as high-level guidance[2]:

[2] Sustainable Development Unit – www.sduhealth.org.uk

- **Climate Change Act 1998** – introduced to ensure the UK cuts its carbon emissions by 80% by 2050. As the largest public sector emitter of carbon emissions, the health system has a duty to respond to meet these targets. A 34% reduction in carbon emissions by 2020 is a key measure of the health system's ambition across the country.

- **National Adaptation Programme** – developed as a response to the UK Climate Change Risk Assessment and sets out what government, businesses, and society are doing to become more climate ready.

- **Carbon Reduction Commitment Energy Efficiency Scheme (CRC)** – a mandatory energy efficiency scheme affecting the majority of larger healthcare organisations, particularly NHS trusts.

- **Civil Contingencies Act** – establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level.

- **The European Union Emissions Trading System (EU ETS)** – the first large emissions trading scheme in the world, launched in 2005 to combat climate change it requires participating organisations to monitor and report their CO2 emissions.

In January 2014, the SDU published '**Sustainable, Resilient, Healthy People & Places – A Sustainable Development Strategy for the NHS, Public Health and Social Care System**'. This Strategy outlines a vision and three goals to aim for by 2020:

Vision

A sustainable health and care system works within the available environmental and social resources protecting and improving health now and for future generations. This means working to reduce carbon emissions, minimising waste and pollution, making the best use of scarce resources, building resilience to a changing climate and nurturing community strengths and assets.

Goal 1: A healthier environment

Goal 2: Communities and services are ready and resilient for changing times and climates

Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments

Making you a Good Corporate Citizen

The Good Corporate Citizen is a tool to help organisations assess how sustainable they are. The tool is not just about measuring fuel bills or waste, but is about evaluating sustainability across the board in financial, social and environmental terms. It enables the CCG to put a measure on how well its activities support sustainability within the organisation and outside in the community.

The assessment is made up of 441 indicators, split across 9 areas:

- Corporate Approach
- Procurement
- Workforce
- Buildings
- Models of Care
- Travel
- Facilities Management
- Community Engagement
- Adaptation

The indicators are categorised as: Getting Started (worth 1 point), Getting There (two points); and Excellent (three points) – for each one, the CCG has scored itself as Yes, No, or Not Applicable.

The CCG's first assessment, carried out in February 2015, resulted in a score of **35%**. In April 2016, the CCG undertook a further assessment, and showed an **improved score of 46%.** Further details are set out within the report outlining the work the CCG has undertaken to improve its score this year.

The following table sets out the scores for each of the 9 areas, demonstrating improvement over the last 12 months:

Area	2014/15 (%)	2015/16 (%)
Corporate Approach	39	83
Travel	37	45
Procurement	16	18
Facilities Management	28	51
Workforce	43	52
Community Engagement	59	52
Buildings	65	69
Adaptation	40	49
Models of Care	39	56

Last year, we explained that the Tool only allows 10% of indicators to be scored as Not Applicable, which is challenging for the CCG as a number of sections do not relate to functions that are within our gift. For example, a number of indicators relate to new building and refurbishment projects, which are not the responsibility of the CCG. Where possible, the CCG interpreted the indicators in line with the functions of the CCG, but identified that 20% of indicators were likely to be 'not applicable'. The indicators had to be scored as 'no', which impacted on the overall score.

During the course of this year, the CCG has continued to work on the interpretation of the indicators in relation to its functions, and has not managed to keep the number of 'not applicable' indicators within the 10% limit.

The Tool envisages a number of targets:

- In the CCG's first year (2013/14) – 25% in each area (all Getting Started, and a few Getting There actions)
- By 2015 – 50% in each area (all Getting Started and Getting There actions)
- By 2020 – 75% in each area (all Getting Started and Getting There, and half of the Excellent actions)

The table below sets out a more detailed breakdown of the CCG's achievements:

Area	Getting Started		Getting There		Excellent	
	2014/15	2015/16	2014/15	2015/16	2014/15	2015/16
Corporate Approach	100%	100%	67%	100%	0%	67%
Travel	44% (17% N/A)	50 % (11% N/A)	39% (28% N/A)	67% (6% N/A)	17% (11% N/A)	22%
Procurement	50% (22% N/A)	50%	22% (22% N/A)	22% (6% N/A)	0% (17% N/A)	0%
Facilities Management	61% (17% N/A)	89%	33% (22% N/A)	67% (17% N/A)	6% (6% N/A)	11% (6% N/A)
Workforce	78%	78%	56%	67%	22% (6% N/A)	28% (6% N/A)
Community Engagement	72% (6% N/A)	72%	56% (11% N/A)	61%	33% (17% N/A)	39%
Buildings	33% (56% N/A)	33% (56% N/A)	22% (56% N/A)	22% (50% N/A)	0% (67% N/A)	0% (61% N/A)
Adaptation	67% (22% N/A)	67% (11% N/A)	44% (33% N/A)	56% (11% N/A)	28% (44% N/A)	28%
Models of Care	72% (6% N/A)	89%	61%	72%	11%	33%
TOTAL	**61%** (18% N/A) ⇨	**67%** (10% N/A)	**42%** (21% N/A) ⇨	**55%** (11% N/A)	**14%** (20% N/A) ⇨	**21%** (9% N/A)

Our Performance against our Sustainability Objectives

The Sustainable Development Unit has identified eight modules and measures of success to deliver the national Sustainable Development Strategy:

- Leadership, Engagement and Workforce Development
- Carbon Hotspots
- Sustainable Clinical and Care Models
- Healthy, Sustainable and Resilient Communities
- Innovation, Technology and Research and Development
- Creating Social Value
- Integrated Metrics

In June 2015, the Governing Body approved its Sustainable Development Management Plan for 2015/16 and set a number of objectives, including specific targets to reduce the CCG's carbon footprint. We have detailed our progress against these objectives below:

Area of Focus	SDMP Objective (as set out in SDMP 2015/16)	Progress Update
All Areas	Host a Sustainability Summit, attended by the CCG's sustainability champions, to develop an action plan to drive the CCG's achievement of all Getting Started and Getting There indicators on the Good Corporate Citizen Tool.	• A series of Sustainability Forums in conjunction with key partners across Kirklees, including Kirklees Council and North Kirklees CCG, have been arranged commencing in April 2016. • The CCG's achievement against the Getting Started and Getting There indicators on the Good Corporate Citizen Tool is set out on page 36
Leadership, Engagement and Development	Continue our work with the Staff Forum, seeking their help to recruit sustainability champions across the organisation, and continue to develop initiatives for office efficiency and a healthy workforce.	• Work has taken place to introduce Sustainability Champions across all CCG teams. Further work is planned to develop this role in conjunction with the Staff Forum. • Work is underway to ensure that sustainability is integral to the new Workforce Strategy which is currently being developed, with particular focus on health and well-being of staff.
	Use our AGM to share our sustainability vision with service users and the public, and encourage them to think what this means for them and how everyone can play their part through healthier lifestyles and reducing waste.	• The CCG held its AGM in July 2015 and shared our sustainability vision as part of the presentation at the main meeting.
	Introduce new technology to host webinars, as a way of engaging people and delivering learning in an environmentally and socially friendly way.	• The CCG has run a number of webinars since June 2015, and has used this as a way of communicating with practices, and delivering training.
Carbon Hotspots	Review the SDMP for 2015/16, incorporating the new information relating to our data and carbon footprint, and set a number of carbon reduction goals and specific projects to achieve them.	• The CCG set itself three specific carbon reduction targets in June 2015: Utilities – 5% Business Miles – 5% Paper – 25% • Our performance against these objectives is set out on page 39.
	Learn from others, by reviewing existing good practice on delivering ambitious carbon reduction, and building this in to our plans	• This work remains ongoing.

Commissioning & Procurement	Reduce the environmental impact of the office products we buy and use less. This will involve reviewing stock and ordering processes to prevent wastage and improving office use of resources.	• The Corporate Team has reviewed all stock ordering to ensure that where the CCG can purchase a product with a smaller environmental impact, that this option is considered. • Stock control processes have also been revised to prevent wastage and improve office use of resources. • Regular awareness raising work is undertaken with staff.
Sustainable Clinical & Care Models	Award the contract for delivering the new specification for community services.	• Contract awarded in October 2015, new integrated model now in place. • All services now implemented. • Planning for phase 2 continues.
	Implement the new integrated model for the delivery of community based health services for a service start of October 2015.	
	Move to phase 2 of Care Closer to Home – continue to enhance and strengthen community services, setting out our expectations for the delivery of those services which we identify that can be provided more appropriately in communities and begin to move them out of hospital settings.	
	Phase 3 - in parallel with the above continue with our Hospital Services Programme. The aim of the programme is to define and commission the future model of Hospital services for Calderdale and Greater Huddersfield. We are clear that transformational change is needed in our hospital services to meet current and healthcare needs. We expect to be able to demonstrate readiness for consultation during Autumn 2015, when we can demonstrate that we have put in place enhanced and integrated community services that will meet local population needs.	• A decision was made in October 2015 that we were not ready as CCGs to progress consultation. • A further joint meeting was held with Calderdale CCG in January 2016, and the decision was made that the CCGs were ready to consult. • Consultation commenced on 15 March 2016 and will conclude on 21 June 2016. A decision is expected in October 2016.
Healthy, Sustainable & Resilient Communities	We are keen to continue learning from our CCG neighbours and other colleagues in the health and social care sector.	• The CCG's Sustainability Lead and Governance & Corporate Manager have met with Kirklees Council to look at links between the CCG's sustainability work plan and the Kirklees Joint Health & Well-Being Strategy and Kirklees Economic Strategy.
	Be an advocate for sustainability as we work with our partners across the health and social care system at the Health & Well-Being Board.	

Our Carbon Footprint

Utility Usage – target 5% reduction

The CCG continues to experience difficulties in obtaining utilities data from NHS Property Services, who are our landlords, in order to identify our utility usage. The CCG has so far been unable to access any information on utility usage for 2015/16.

As a tenant in a multi-occupier building, which has a significant amount of vacant space, identifying the CCG's utility usage is particularly challenging. Calculations for utility usage in 2013/14 and 2014/15 have been based on an estimate that the CCG is responsible for 30% of the building's utility usage.

The CCG runs regular awareness raising campaigns with staff, to encourage staff to be mindful.

Business Miles – target 5% reduction

The CCG continues to work closely with our payroll provider to identify the number of business miles claimed by staff during 2015/16. Information relating to public transport is not currently extractable. We will continue to investigate how this could be monitored.

Since April 2015, the CCG has run a successful campaign 'Cars in the Jar' to encourage staff to car share and avoid unnecessary journeys. We know we **saved over 250 journeys** during the year.

The CCG has experienced a significant increase in the number of staff during the course of 2015/16, which makes it difficult to accurately compare with previous years. There has been a 14% increase in business miles claimed during 2015/16; however this should be seen in the context of the increased number of staff.

The CCG intends to carry out further analysis of business miles travelled and claimed during 2015/16 in order to improve the accuracy of reporting.

Paper Usage – target 25% reduction

The CCG set itself an ambitious 25% reduction target for paper. Following the implementation of new systems and staff awareness raising, the CCG has achieved a **significant 46% reduction in paper usage**.

Waste

Responsibility for general waste collection lies with NHS Property Services and the CCG have been unable to obtain any data for 2015/16. Data for 2013/14 and 2014/15 is based on a 30% estimate of the total building collection. All waste data is based on the number of bin lifts, rather than weight. It is not known whether bins were full at the point of collection, and the data provided may therefore be an overestimate.

The CCG is responsible for recycling waste collection and confidential waste collection and this data is therefore included.

Targets for 2016/17

Carbon Footprint Table

Resource	Quantity			CO^2 Emissions (tonnes)			Cost (£)		
	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16	2013/14	2014/15	2015/16
Gas (kWh)	70,122	47,413	*	14.8	9.9	*	£2,668	£1,898	*
Electricity (kWh)	130,696	106,193	*	73.2	65.8	*	£16,691	£14,814	*
Business Miles Travelled (miles)	39,088	46,870	53,261	14	17	20	£21,579	£27,737	£29,087
Public Transport Miles	-	-	-	-	-	-	-	-	-
General Waste (tonnes²)	7	5.1	*	1.7	1.2	*	£471	£609	*
Recycling (including confidential waste) (tonnes²)	1.8	1.9	*	0.03	0.04	*	£313	£1,004	£807
Water (m^3)	583	917	*	1	1	*	£2,469	£3,160	*

* Please note utility usage and waste figures not currently available from NHS Property Services.

The Performance Report – Statutory Duties

The CCG is required to comply with a number of statutory duties. During 2015/16, the CCG's Audit Committee monitored compliance with each of these duties, to provide assurance that the CCG is meeting its statutory duties. We have sought to demonstrate throughout the Annual Report our compliance with our statutory duties.

Whilst we have complied with all of our statutory duties, the Health & Social Care Act 2012 (as amended) includes a number of legislative requirements for CCGs in respect of the information we must include in our Annual Report. In this section, we have summarised our activities in two key areas:

Public Involvement and Consultation
(Section 14Z2, Health & Social Care Act 2012 (as amended))

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

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

- Primary Care Services
- Practice Based Services, including: podiatry services based at Elmwood; Kirkburton teenage clinic; services based at the University; and dermatology at Meltham Road.
- Right Care, Right Time, Right Place, including: urgent and emergency care; planned cate; therapies and technology; and maternity and paediatric services
- Care Closer to Home
- Early Pregnancy Assessment Unit and emergency gynaecology.
- Ophthalmology
- Autism Spectrum Condition (ASC)

In addition to the engagement activity we have delivered, there are a number of mechanisms which support us to engage local people, including:

- Community Voices – a new programme to train voluntary and community sector representatives who help us to engage grass roots communities and protected groups.
- Patient reference group members who work directly with individual practices and attend a Patient Reference Group Network (PRGN) on a quarterly basis to share their views.
- Working in partnership with Local Authority colleagues to engage communities and reach children and young people.
- A dedicated website which contains information on how to contact the CCG and updates people on our engagement activity. This includes the use of social media such as Twitter to gather views.
- A complaints and PALS service who capture public views as part of their customer facing role, which we use to inform our engagement approach.
- Close working relationship with Healthwatch colleagues to ensure we listen to people's views through consumer champions.
- Existing consumer websites are reviewed including those attached to the local media, patient opinion and NHS Choices to gather feedback.

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

Community Voices

Community Voices work in partnership with the CCG to talk to local communities and individuals about changes and developments in local healthcare. We currently have 41 trained volunteers across 32 local voluntary and community groups.

Trained volunteers acts as a link for their voluntary and community sector group and the CCG to make sure that the views of a wide range of local people are heard. We would not be able to engage with these people, who are often the most vulnerable members of our local population without the support of our volunteers.

As part of the training, volunteers gathered views from their local groups on primary care services. We received 240 responses from a range of local people who told us:

- Primary care provision needs to reflect local demographic needs
- General Practice need to look at their community when providing services
- Information and communication should be appropriate
- Practice staff need to understand the local community

Reducing Inequalities
(Section 14T, Health & Social Care Act 2012 (as amended))

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

- Active membership of the Health and Wellbeing Board;
- Active engagement in the development of the Joint Health & Wellbeing Strategy;
- Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions;
- Testing the Five Year Strategic Plan and Operational Plan against the Joint Strategic Needs Assessments and the Joint Health & Well-Being Strategy.

Consultation and Work with the Health & Wellbeing Board
(Health & Social Care Act 2012 (as amended))

The CCG continues to be an active member of our local Health & Wellbeing Board and throughout the year the CCG has either presented or been actively involved in many of the items under discussion at the Board. These are reflected throughout the Annual Report and include:

- Right Care, Right Time, Right Place
- Developing integrated commissioning in Kirklees
- Care Closer to Home and Early Intervention and Prevention
- Quality Premium
- CCG Operational Plan

- Joint Health & Well-Being Strategy – outcomes and system changes
- Local Transformation Plan – Future in Mind
- Primary Care Strategy
- Care Home Strategy
- Health related worklessness
- Kirklees Integrated End of Life Care Vision
- Local Plan
- Pharmaceutical Needs Assessment
- Dementia Strategy
- West Yorkshire Emergency Care Vanguard
- Transforming services for Children and Young People
- Kirklees Carers Charter
- Kirklees Safeguarding Adults Board 3 Year Strategic Plan

The CCG has also participated in work this year to develop the Health & Wellbeing Board.

Ensuring the Continuous Improvement in Quality
(Section 14R, NHS Act 2006 (as amended))

Ensuring patient safety and improving quality is core to our business. The relationship between the CCG as commissioners and our providers is critical in taking forward the learning from national reviews such as Francis and Winterbourne and more recently the Kirkup[1] report and The Mazars report, Independent Review – Southern Health NHS Foundation Trust.

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

- Local CQUIN(Commission for Quality and Innovation) targets
- Supporting incident reporting and sharing lessons learned particularly across the whole system
- Being Members of the Local Patient Safety Improvement Collaborative with a view to participating in Sign up to Safety
- Developing the use of quality impact assessments to ensure that we understand the impact of any commissioning decisions on quality
- Developing the use of patient experience information to make improvements in partnership with our providers

Carol McKenna **Date: 24 May 2016**
Accountable Officer

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

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report 2015/16

The Accountability Report

The Accountability Report

This section of the Annual Report enables the CCG to meet key accountability requirements to Parliament. In this section you will find:

- **The Corporate Governance Report, which includes:**
  - **The Members' Report**
  - **The Statement of Accounting Officer's Responsibilities**
  - **The Governance Statement**
- **The Remuneration and Staff Report**

Corporate Governance Report - Members' Report

Our Member Practices

NHS Greater Huddersfield CCG is a membership organisation that consists of 38 GP practices:

Almondbury Surgery	Lockwood Surgery
Birkby Health Centre	Marsh Surgery
Bradford Road Medical Centre	Meltham Group Practice
Clifton House Surgery	Meltham Road Surgery
Colne Valley Family Doctors	Meltham Village Surgery
Crosland Moor Surgery	The New Street Surgery
Dalton Surgery	Newsome Surgery
Dearne Valley Health Centre	Oaklands Health Centre
Elmwood Health Centre	Paddock and Longwood Family Doctors
Fartown Green Road Surgery	Shepley Health Centre
Fieldhead Surgery	Skelmanthorpe Family Doctors
Dr Glencross Surgery	Slaithwaite Health Centre
The Grange Group Practice	Thornton Lodge Surgery
Honley Surgery	University Health Centre
Junction Surgery	The Waterloo Practice
Kirkburton Health Centre	Westbourne Surgery
Lepton and Kirkheaton Surgeries	Whitehouse Centre
Lindley Group Practice	Woodhouse Hill
Lindley Village Surgery	Drs Wybrew and Wybrew

From 1st April 2016, the number of practices reduced to 37 following the merger of Elmwood Health Centre and Meltham Village Surgery.

Our Chair and Accountable Officer

Dr Steve Ollerton is the CCG's Chair, and Carol McKenna is the CCG's Accountable Officer.

Our Governing Body

The CCG's Constitution sets out the required composition of our Governing Body

Required Composition	Persons in Post
8 representatives of member practices, one of whom shall be appointed chair.	Dr Steve Ollerton (Chair) Dr Dil Ashraf (until 30 September 2015) Dr Chris Beith (from 1 October 2015) Dr Ramesh Edara Dr Jane Ford Dr Anuj Handa Dr David Hughes Dr Matthew Kaye (from 1 October 2015) Dr Judith Parker (until 30 September 2015) Dr Maria Wybrew (until 31 March 2016)

2 lay members, one of whom shall be appointed deputy chair: (i) One to lead on audit, remuneration and conflict of interest matters; (ii) One to lead on patient and public participation matters.	(i) Tony Gerrard (until 31 March 2016) David Longstaff (from 1 April 2016) (ii) Vanessa Stirum (Deputy Chair) (until 31 March 2016) Priscilla McGuire (Deputy Chair) (from 1 April 2016)
1 registered nurse	Angela Monaghan
1 secondary care specialist doctor	Irving Cobden
The accountable officer	Carol McKenna
The chief finance officer	Julie Lawreniuk (until 28 April 2016)
The senior manager with responsibility for quality	Penny Woodhead

The Governing Body is supported in its work by two advisors from the Local Authority – the Director of Commissioning, Public Health and Adult Social Care and the Director of Public Health.

From 1 May 2016, the Governing Body will also be supported in its work by a Lay Advisor, focusing on Financial Management and Primary Care Commissioning.

Our Committees

The Governing Body has appointed the following Committees:

- Audit Committee
- Finance & Performance Committee
- Joint Commissioning Committee (until 31 March 2016)
- Primary Care Commissioning Committee (from 1 April 2016)
- Quality & Safety Committee
- Remuneration Committee

For further information on all our Committees, including their terms of reference and membership please see the Governance Statement (page 50).

Register of Interests

The declared interests of our Governing Body and Committee members are recorded in the CCG's Register of Interests, which can be viewed on the CCG's website at: www.greaterhuddersfieldccg.nhs.uk. A copy of the CCG's Register of Procurement Decisions can also be viewed on the CCG's website.

Disclosure of Personal Data Related Incidents

The CCG has had no personal data related incidents requiring formal reporting to the Information Commissioner's Office.

Statement as to Disclosure to Auditors

Each individual who is a member of the Audit Committee 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 Clinical Commissioning Group's external auditor is unaware; and
- That the member has taken all the steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Carol McKenna **Date: 24 May 2016**
Accountable Officer

Corporate Governance Report – Statement of Accountable Officer's Responsibilities

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

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

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

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

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

To the best of my knowledge and belief:

- I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.
- There is no relevant audit information of which the CCG's auditors are unaware, and I have taken all reasonable steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.
- The Annual Report and Accounts as a whole are fair, balanced and understandable and I take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

Carol McKenna
Accountable Officer

Date: 24 May 2016

Corporate Governance Report – Governance Statement

Introduction and Context

The Clinical Commissioning Group was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006. As at 1 April 2015, the CCG 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 CCG'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. These are referred to throughout the Annual Report and Governance Statement as follows:

- **Leadership**
  - Details of the Governing Body within the Corporate Governance Report
- **Effectiveness**
  - Governing Body Performance, within the Corporate Governance Report
  - Members' Report, within the Annual Report
- **Accountability**
  - Performance Report, within the Annual Report
  - Risk Management Framework, within the Corporate Governance Report
  - Audit Committee details, within the Corporate Governance Report
- **Remuneration**
  - Remuneration and Staff Report, within the Annual Report
- **Relations with Shareholders**
  - Performance Report, within the Annual Report

The CCG's Audit Committee undertakes regular monitoring of the CCG's compliance with the provisions of the Code, identifying where action is needed, and will continue to do so in 2016/17.

During 2015/16, work has been undertaken to strengthen the CCG's compliance in the following areas:

- Chair's meetings with Lay Members and Clinical Advisors
- Embedding an induction process for new Governing Body members

The Audit Committee will continue to monitor the CCG's compliance with the UK Corporate Governance Code in 2015/16.

The CCG 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.'***

Key Governance Features of the CCG's Constitution

NHS Greater Huddersfield CCG is a membership organisation that consists of 38 GP practices (37 from 1 April 2016). The CCG's Constitution, as agreed by the member practices, sets out the arrangements made by the CCG to meet its responsibilities for commissioning care for the population. It describes the governing principles, rules and procedures that we have established to ensure probity and accountability in the day to day running of the CCG, to ensure that our decisions are taken in an open and transparent way, and that the interests of patients and the public remain central to our goals.

The CCG's Scheme of Reservation and Delegation sets out:

- those decisions that are reserved for the membership as a whole;
- those decisions that are the responsibilities of the Governing Body (and its committees), the CCG's committees and sub-committees; individual members; and employees.

The CCG remains accountable for all of its functions, including those that it has delegated.

Governing Body

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

The membership currently comprises the eight GPs (including the chair) as endorsed by the membership; two lay members (one of whom is the deputy chair and leads on public and patient involvement matters and one who leads on audit, remuneration and conflict of interest matters); one registered nurse; one secondary care specialist; the Accountable Officer, the Chief Finance Officer and the Head of Quality and Safety.

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

From 1 April 2016, the Governing Body is also supported by a Lay Advisor focusing on Financial Management and Primary Care Commissioning.

Committees of the Governing Body

In 2015/16, the Governing Body had five committees to support its work. The full terms of reference of these committees are available at www.greaterhuddersfieldccg.nhs.uk. From 1 April 2016, the Governing Body appointed a new committee – the Primary Care Commissioning Committee – to support its new delegated commissioning responsibilities.

The CCG's Committees

Role of the Committees

Audit Committee

The role of the committee is to provide the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG insofar as they relate to finance. The committee is also responsible for a number of other functions, under delegated powers from the Governing Body – Integrated Governance, Information Governance, and the Risk Management Framework.

The Committee met 8 times between 1 April 2015 and 24 May 2016, and was quorate on all occasions (full details at Appendix 1).

Finance & Performance Committee

The role of the committee is to advise and support the Governing Body in scrutinising and tracking delivery of key financial and service priorities, outcomes and targets as specified in the CCG's Strategic and Operational Plans.

The Committee met 13 times from 1 April 2015 to 24 May 2016 and was quorate on all occasions (full details at Appendix 1).

Quality & Safety Committee

The role of the committee is to support the Governing Body by providing assurance that effective quality arrangements underpin all services provided and commissioned on behalf of the CCG, regulatory requirements are met and patient safety is continually improved to deliver a better patient experience. It supports the Governing Body in ensuring that commissioning decisions are based on evidence of clinical effectiveness, protects patient safety and provides a positive patient experience in line with the principles of the NHS Constitution and requirements of the Care Quality Commission.

The Committee met 13 times from 1 April 2015 to 24 May 2016 and was quorate on all occasions (full details at Appendix 1).

Remuneration Committee

The role of the committee is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determinations about allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme.

The Committee met 6 times from 1 April 2015 to 24 May 2016 and was quorate on all occasions (full details at Appendix 1).

Joint Commissioning Committee

From 1 April 2015, the CCG established a joint committee with NHS England for the purpose of jointly commissioning primary medical services for the people of the Greater Huddersfield area. This arrangement was in place until 31 March 2016, with a new system of fully delegated commissioning taking effect from 1 April 2016 (see Primary Care Commissioning Committee below).

The role of the Joint Commissioning Committee was to carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act. This did not include individual GP performance management, as this is carried out by NHS England.

The Committee met 7 times during its currency from 1 April 2015 to 31 March 2016 and was quorate on all occasions (full details at Appendix 1).

Primary Care Commissioning Committee

From 1 April 2016, the CCG established a committee for the purpose of commissioning primary medical services for the people of the Greater Huddersfield area, under full delegation from NHS England.

The role of the committee is to carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act. This does not include individual GP performance management, as this is carried out by NHS England.

The Committee met twice between 1 April 2016 and 24 May 2016 and was quorate on each occasion (full details at Appendix 1).

Committee Membership and Attendance Records

Details of the membership of the Governing Body and its Committees are set out on page 73 – this also includes each member's attendance record over the past year.

Governing Body – Assessment of Performance and Effectiveness

In March 2016, the Governing Body undertook its annual assessment of its own performance during 2015/16. This self-assessment, which also took into account feedback from those who regularly attend the meeting but are not members, focused on 36 aspects of good governance.

Governing Body members highlighted a number of areas of particular strength:

- The Governing Body is open and transparent in the way it conducts its business.
- The Governing Body is focused on the development of the CCG as a high performing membership organisation.
- The Governing Body is able to appropriately manage conflicts of interest.
- The Governing Body operates within the CCG's Constitution, Standing Orders and Standing Financial Instructions.
- The Governing Body is assured that all its statutory duties and responsibilities are being effectively discharged.
- The Governing Body's committee structure is appropriate to deal with the business of the organisation.

The Governing Body identified that significant progress had been made in respect of:

- Ensuring the right balance between strategic and operational discussions at the Governing Body meetings.
- Ensuring sufficient challenge and scrutiny in meetings.
- Evolving the way in which Governing Body can make best use of patient and public experience and engagement information, and ensure that patients are visibly at the heart of the CCG's business.

- Governing Body members being provided with sufficient training to support their role.

Governing Body members will continue to focus on the above areas over the following 12 months and have also agreed to specifically focus on encouraging contribution from all members of the Governing Body across the full breadth of discussions in meetings.

Committee Highlights

Our committees have identified a number of highlights from their work to date:

Audit Committee

- The Committee's work underpins the work of the rest of the organisation, enabling its governance arrangements to work in a more effective and safer manner.
- The overviews of the risks and controls concerning Financial Management, Quality & Safety, and Contracting & Procurement continue to play a major part in the Committee's understanding of the CCG's operations.
- Risk Register and Board Assurance Framework reporting continues to improve.

Finance & Performance Committee

- Renewed focus on the CCG's financial recovery programme.
- Scrutinising the system wide financial implications of the Right Care, Right Time, Right Place proposals.
- Initiated non-elective clinical audit to understand the overtrade position at Calderdale & Huddersfield NHS Foundation Trust.

Joint Commissioning Committee

- The decision to approved the proposed merger of Elmwood Family Doctors with Meltham Village Surgery – this has resulted in additional services being available to the patients registered with Meltham Village Surgery and the introduction of more nursing time at Meltham Village due to more efficient ways of working.
- Approval of a quality scheme for all Greater Huddersfield practices – supporting practices to identify areas where they are doing less well and to focus their work on improving these areas beyond the requirements of the core contract.
- Agreement of a local quality framework for the University Practice, enabling that practice to enhance the quality of care for their specific population which is predominantly students.

Primary Care Commissioning Committee

- This Committee was established on 1 April 2016, following approval of the CCG's application to take on full delegation of primary care commissioning, which will lead to more decisions being taken locally.

Quality & Safety Committee

- The Quality Issues Alert System – an easy to use alert system that provides primary care with an opportunity to tell the CCG about quality issues –has seen an increase in usage in 2015/16 with 37 out of 38 practices using the system. Software development has also taken place to support the reporting function.
- A safeguarding training programme has been developed and delivered for both clinical and non-clinical staff within our GP practices.

- Community asset training – this approach supports the public voice and encourages participation from communities that are sometimes the hardest to be reached. 41 assets have been trained this year. For further information, please see page 41.

Remuneration Committee

- The Committee has reviewed a number of key policies during the year, including the Whistleblowing Policy.
- The Committee has worked on Terms and Remuneration including: Very Senior Manager contracts and salaries

The CCG Risk Management Framework

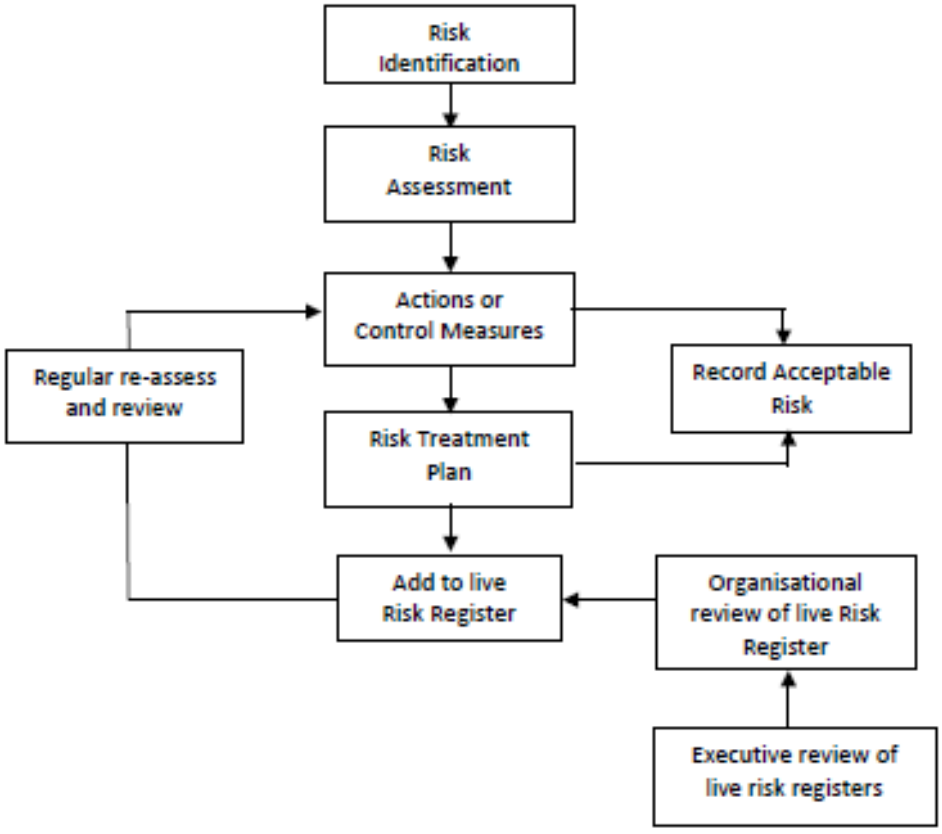
The CCG has an Integrated Risk Management Framework in place, which was developed during the establishment period and first approved by the Governing Body on 3 April 2013. The Framework was reviewed by our Audit Committee in September 2015 and the revised Framework subsequently approved by the Governing Body in October 2015. The Framework describes our approach to managing risk.

The CCG is dedicated to ensuring a positive risk management culture is in place that ensures that risk management is an integral part of everything we do. This is supported by a comprehensive system of internal controls and risk management processes aligned to the working of the CCG to assure the Governing Body and our member practices that the CCG is doing its reasonable best to protect stakeholders against risks and is capable of delivering its strategic priorities.

The Framework sets out five strategic objectives for risk management:

1. Identify, Report and Manage Risk and Embed within the Commissioning Process

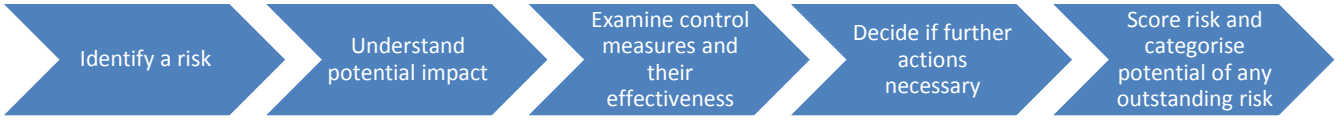
The CCG's Risk Assessment and Management process is illustrated in the chart below:



Risk can only be managed if it is identified, and 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 within statutory and regulatory requirements;
- 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 – Senior Management Team, Governing Body, Quality and Safety Committee, Finance and Performance Committee, and Audit Committee, which highlights problems and issues which should be reflected in the risk register;
- Risk identification is also supported through review processes using the live risk register including team and contract review meetings.

A structured process is used for risk assessment:



The risk score determines the prioritisation and allocation of resource, and is achieved by multiplying the potential consequence or severity by the potential likelihood or frequency level to provide a risk score utilising the 5 x 5 matrix scoring system:

Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

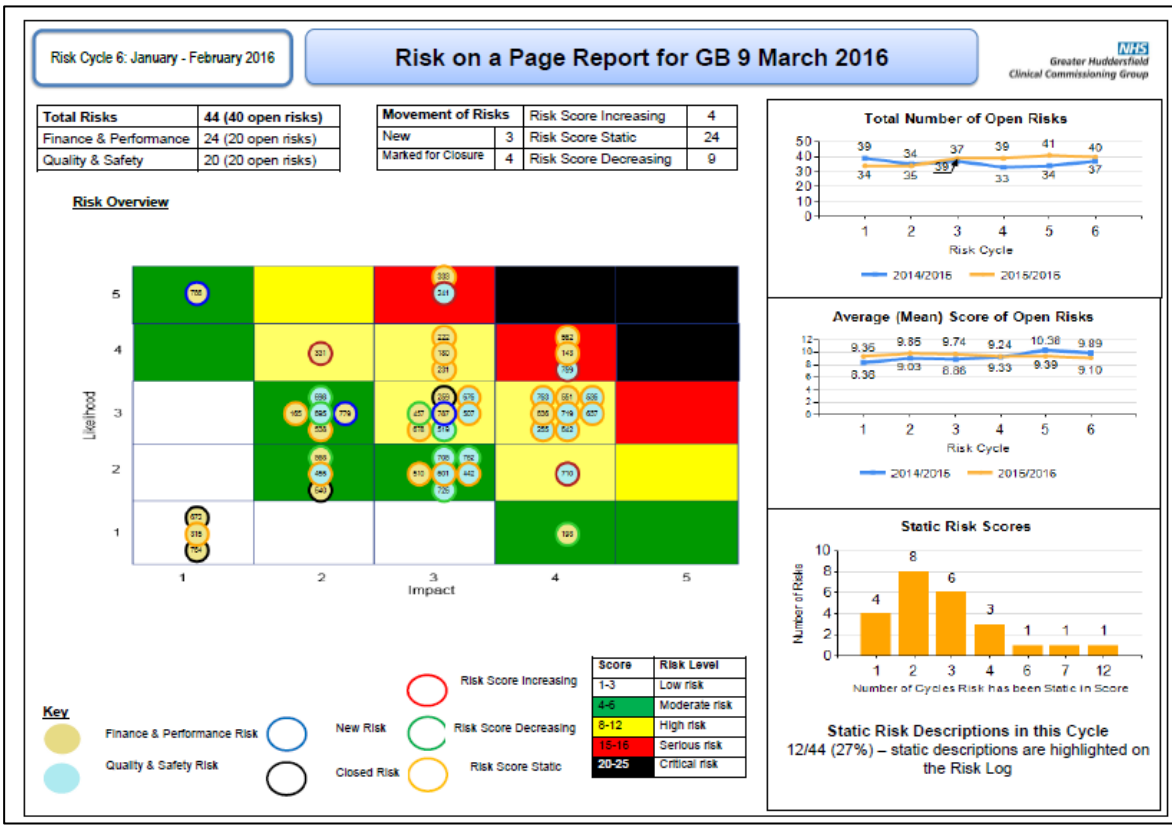
Risk Grading		Priority No
Critical Risk (20-25)	**Black**	1
Serious Risk (15-16)	Red	2
High Risk (8t-12)	Yellow	3
Moderate Risk (4-6)	Green	4
Low Risk (1-3)	Clear	5

In 2015/16, the CCG agreed to review the criteria for the evaluation of financial risk impact, as it was felt that these may not be fit for purpose due to the low values attributed to each score, in the context of the overall CCG budget. It was recognised that this could result in an overstating of the level of financial risk, and the Governing Body therefore agreed to amend the criteria to bring it in line with the National Patient Service Authority guidance.

The CCG has an integrated approach to risks, with the management of risks co-ordinated through a single corporate Risk Register, no matter whether the risks relate to clinical quality, finance, performance or corporate matters.

Risk owners identify and report risks onto the system and regularly review and update all their risks. Senior managers are responsible for ensuring the review process is conducted in a timely and accurate manner and for ensuring the risk score and quality of information is fit for purpose. Clinical Leads are responsible for supporting and working with managers and risk owners to identify and manage risk within their own specialist areas. The ultimate management of risk lies with the CCG Governing Body which reviews the High Level Risk Log every risk cycle.

The CCG's *Risk on a Page* report, which is reviewed by Senior Management Team, Committees and Governing Body, provides a visual overview of the CCG's risk profile.



In respect of risk appetite, the High Level Risk Log reports all risks that are scored as 15 or above (ie deemed to be serious or critical) to the Audit Committee and Governing Body. If a risk scoring 20 or above is added to the risk register, or an existing risk escalates to 20 or above, a critical risk report is immediately sent to Governing Body members, rather than waiting for the full review cycle to be completed.

The Risk Register identifies and manages performance based risks that may rise and fall within relatively short term periods – in essence, our operational risks. The Assurance Framework is a Governing Body level assessment of the organisation's objectives and the risks that may prevent or hinder the objectives being achieved. It includes an assessment of the controls that are in place to manage the identified risks. The sources of assurance received by the Governing Body are analysed and documented in the framework. Any gaps in assurance or controls are identified and suitable action plans developed to address them.

The Board Assurance Framework is reviewed quarterly and agreed by the Audit Committee and Governing Body as a true and fair reflection of strategic risks, and evidence that satisfactory progress is being maintained to manage risk.

In January 2016, Internal Audit undertook a review to ensure that:

- The CCG's governance structure and reporting lines comply with guidance and enable the CCG to discharge its duties and responsibilities, including obtaining all necessary assurances, in full and effectively.
- The Assurance Framework is fit for purpose and identified and manages risks effectively and is regularly reviewed.
- Conflicts of interest are properly managed and comply with legislation and guidance.

The review resulted in Significant Assurance, with a small number of recommendations. The CCG has put in place an action plan to ensure the completion of these recommendations.

2. Capture and Learn from Risk to Prevent Recurrence of Risk

An effective risk management process learns from experience, so that risks do not recur. The CCG's process has two main elements:

- **Learning from experience in the organisation**
  The CCG is committed to an improvement philosophy – when things go wrong, we want to learn from them. We are also committed to honesty and openness; involving patients, partners, stakeholders, families and staff in our learning processes; and ensuring appropriate responses in our investigations when things do go wrong.

  We have the opportunity to gather valuable learning information from a range of systems and activities, and we have processes in place to capture this learning. This includes:
  - Reviewing the risk register for closed risks to assess whether there are any issues which need to be incorporated in processes to minimise occurrence in future.
  - Investigating incidents, complaints and claims using root cause analysis to identify underlying issues which require improvements or interventions to reduce the chance of recurrence. The reporting of all incidents or near misses is encouraged, and recorded on the DATIX system. Reports on clinical incidents are taken to the Quality and Safety Committee and the numbers of corporate incidents are reported by category to the Audit Committee. This information helps to inform plans to prevent recurrence.
  - Triangulation of intelligence on complaints, incidents and claims with soft intelligence and feedback from stakeholders.

- **Learning from others and using best practice**
  We collate information from a range of data sources, including:
  - Feedback from external reviews of organisational systems – for example, internal audit, Care Quality Commission reviews, Ofsted, and the Ombudsman.
  - Using local and national professional networks to identify best practice and benefit from the experience of others.
  - Research and guidance published by professional bodies.
  - Recommendations from external investigations and formal inquiries.

3. Ensure Clear Accountability for Risk Management

An effective accountability framework for the management and reporting of risk is in place, which separates the CCG's internal governance arrangements for risk processes and management of risk, and accountability to NHS England for the operational management of risk. Risk management is embedded into the activities of the CCG.

4. Ensure Statutory and Regulatory Compliance

The Risk Management Framework is designed to support the collection of evidence to comply with external assessments and best practice by, for example:

- Scheduling programmes of work for baseline self-assessment for key areas of compliance – for example, Care Quality Commission standards.
- Scrutiny of the effectiveness of the governance arrangements by the Audit Committee.

5. Manage Partnership Risks

The key partners for the CCG include a number of NHS providers, the Local Authority, independent contractors including Locala, and the voluntary sector. In addition to having robust internal scrutiny arrangements; the organisations are required to contribute to joint "risk registers" and frameworks with partner organisations. This recognises the need to manage risk across organisations and partnerships to deliver whole system change and improvement.

The CCG also has a number of major projects including Right Care, Right Time, Right Place; Continuing Healthcare; and the Better Care Fund which have their own risk registers and which are captured on the CCG's main risk register.

The CCG's key control mechanisms of the Risk Register and Board Assurance Framework, as set out above, are complemented by a range of other control mechanisms designed to deliver assurance around: prevention of risk; deterrents to risks arising; and management of current risks. These include:

- The CCG has approved an Anti-Fraud, Bribery and Corruption Policy, which has been reinforced by mandatory training for both employees and Governing Body Members. There is a clear link on our intranet for all staff to confidentially report suspected fraud.
- The CCG has a Business Continuity Plan in place, which sets out the CCG's contingency plans to maintain an effective service in the event of a critical incident.
- The CCG undertakes regular health and safety, fire and premises risk assessments.
- The CCG makes use of equality and diversity expertise, guidance and support to ensure that we are compliant with the Equality Act 2010 Public Sector Equality Duty. All CCG staff are required to complete mandatory equality and diversity training, which helps staff identify those CCG policies, Governing Body papers and improvement programmes that will require an equality impact assessment.

Risk Assessment

Risk assessments in relation to governance, risk management and internal control are carried out in three ways by the organisation:

- Through internal governance arrangements taking account of self-assessment activity, the annual review of the CCG constitution, new national guidance or regulations, and external inquiries such as the Francis Review or the Winterbourne Review.
- Through the identification of targeted work by the West Yorkshire Audit Consortium as part of the Internal Audit work plan, which focuses on areas within the organisation that require strong governance and risk management arrangements in place.
- Through external audit through the year by KPMG.

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

Risks to Governance, Risk Management and Internal Control

As set out above, the CCG's corporate risk register details all risks relating to governance, risk management and internal control during the course of the year or after year end. We have identified below those risks to governance, risk management and internal control deemed to be major (ie scoring 15 or above) up to 24 May 2016:

Risk	Action to manage	Assessment of outcome
There is a risk that Children's Continuing Healthcare expenditure will continue to increase in 2016/17 resulting in an inability to meet financial targets due to a number of financial challenges. (Created 2016/17)	• Work to fully understand the financial implications of the areas of concern. • Full review of all individuals in receipt of funding and reductions in care packages ongoing. • Reviewed Scheme of Delegation to be implemented and audited.	Financial impact to be fully considered, and presented to Committee with recommendations & action plan.
There is a risk of lack of appropriate support to individuals who currently hold a Personal Health Budget (PHB) and the organisation, due to Doncaster CCG (host organisation) currently being unable to provide a service that can accept new referrals. This is resulting in increased workload for the Continuing Care (CC) Team and delays in some PHBs being put in place for people who have requested a PHB, as well as potentially unlawful arrangements in place for individuals transferring to CHC with a LA Direct Payment in place. (Created 2015/16)	• Increased contact with any individuals currently in receipt of a PHB to ensure running smoothly. • Agreed increased funding to recruit to deliver internally.	Individuals with PHB are well known to the CC Team. Contact will be made where it is known there may be current risks to the PHB package.
Risk that the CSU/CCG is not able to maintain/recruit to a stable workforce during transition to our new commissioning support arrangements impacting on the CCG ability to deliver its business. Following transition and the closure of the CSU our key risks relates to recruiting to vacancies within the structure. (Created 2015/16)	Yorkshire & Humber Transition Board established. Senior Management Team weekly review of position. TUPE of staff to CCG from CSU. New structure approved and priority for recruiting to vacancies agreed.	TUPE transfer completed. Majority of recruitment completed.
There is a risk that CHC expenditure will continue to increase in 15/16 resulting in an inability to meet financial targets due to a number of financial challenges. (Created April 2016)	• Work to fully understand the financial implications of the areas of concern. • Full review of all individuals with 1-1 care in allowable rate care services and reductions in care packages ongoing. • Implementation of revised resource allocation process with greater controls and quality assurance. • Implementation of commissioning policy following details of legal support regarding implementation.	Reporting mechanism in place to feed back to Committee on actions within Action Plan.

There is a risk that we do not deliver coordinated change across hospital and community services at sufficient pace and scale, due to the Right Care, Right Time, Right Place Programme not delivering and / or issues with the availability of capital funding, resulting in poor services being established/maintained and financial benefits not being realised. (Created January 2015)	• Programme Boards and governance structure in place including working groups. • Assurance from NHS England on proposals. • Consultation launched on 15 March on proposed future arrangements for hospital and community health services.	Consultation underway.

The CCG's **Board Assurance Framework** describes the principal risks to compliance with our licence and being able to fulfil our strategic objectives:

- Failure to maintain and improve the quality and safety of services due to ineffective assurance resulting in harm to
- Risk that commissioning arrangements for safeguarding do not ensure that providers are effectively safeguarding children and adults due to ineffective safeguarding arrangements with partners, resulting in harm to children and adults
- Risk that patients acquire infections while in receipt of commissioned health services due to poor quality service delivery and inappropriate prescribing of antibiotics, resulting in harm to patients
- Risk of not improving and maintaining patient experience due to:
  - not using patient intelligence appropriately with providers to improve that experience
  - not using patient intelligence to develop commissioning plans or service specifications

  resulting in patient dissatisfaction
- Risk that the CCG does not appropriately consider people with protected characteristics due to lack of effective processes for capturing equality and diversity information resulting in ineffective commissioning decisions and failing to meet statutory duty
- Failure to commission services that deliver effective care and improve outcomes for patients due to:
  - not implementing evidence based practice
  - not facilitating service integration across health and social care, and primary and secondary care
- Risk that patients do not access services due to ineffective communications resulting in patients not getting timely and appropriate access to services
- Inadequate engagement with local authority, other CCGs, providers, practices and stakeholders leading to inadequate health influence in the district
- Risk that the CCG fails to reduce health inequalities due to a lack of appropriate and timely needs information
- Risk that the CCG implements health improvement plans without being able to demonstrate the benefits of these, due to not measuring improvement, resulting in inappropriate commissioning decisions
- Risk of pressure on the Medium Term Financial Plan due to uncertainty of future national planning guidance for 2015/16 (e.g. Continuing Healthcare, Co-Commissioning, Specialised Commissioning, Better Care Fund) resulting in unforeseen financial risk
- Long term financial risk that demand for services increases at a level above annual uplift due to:
  - CCG not reducing reliance on unplanned hospital based care; patient choice; increasing patient expectations; resulting in an affordability gap
- Risk that fail to fulfil our statutory responsibilities and duties due to a lack of robust governance arrangements
- Risk that innovative service transformation is stifled due to:
  - Finance
  - Development of workforce to deliver innovative services
  - Engagement with public and patients
  - Engagement and communication with key stakeholders including local authority, OSC, HWB, MPs, providers
- Risk to CCG as a membership organisation due to member practices not engaging or supporting the CCG resulting in failure to operate within the NHS Constitution

- Risk of inappropriate clinical variation due to failure to address the quality, efficiency and access to general practice
- Risk that do not value and develop our staff due to insufficient investment (time/resource/money)

The CCG undertakes a number of actions which are identified to mitigate the above risks:

- Governance Structures
  The CCG's principal risks are all set out within the Board Assurance Framework, and this is kept under review by the Senior Management Team, Audit Committee, and Governing Body.

- Responsibilities of Heads of Service and Committees
  Each principal risk has an identified Senior Management Team Lead, Governing Body Lead and Clinical Lead. This ensures clear accountability for the management and monitoring of each principal risk. Each Senior Management Team Lead, in conjunction with the other leads, is responsible for regularly reviewing the risk, including assessing the key controls for mitigating the risk, sources of assurance, identifying positive assurance, and where gaps in control or assurance are flagged, identifying corrective action.

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

- Reporting Lines and Accountabilities
  Reporting lines and accountabilities are set out within the CCG's Integrated Risk Management Framework and Committee Terms of Reference. The risk cycle is as follows:

- Submission of Timely and Accurate Information to Assess Risks to Compliance
  The assessment of risks is a continuous process informed by:
  - Senior Management Team identifying new risks or changes to risk profile.
  - Financial, contracting, quality, QIPP and performance reports, which are submitted on a monthly basis to our Finance & Performance Committee and Quality & Safety Committee.
  - Discussions taking place at Finance & Performance Committee and Quality & Safety Committee on the Risk Register and at the Audit Committee and Governing Body on the Assurance Framework.

- Degree and Rigour of Governing Body Oversight Over Performance

The Governing Body receives a number of reports at each meeting to provide it with the necessary degree and rigour of oversight on the CCG's performance. This is supported by detailed discussions and work undertaken by the Committees.

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

The Clinical Commissioning Group 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.

Details of the CCG's control mechanisms are set out in the previous section of the Governance Statement.

Information Governance

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect personal and corporate information. We have established an information governance management framework and have embedded information governance processes and procedures in line with the information governance toolkit including incident reporting and investigation of information security and personal data related incidents.

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

The roles of Senior Information Risk Owner, Caldicott Guardian and Information Governance lead have been assigned and appropriately trained to fulfil the responsibilities of their role. Until March 2016, the CCG was supported by the Yorkshire and Humber Commissioning Support (CSU) Information Governance Team. From 1 March 2016, following the closedown of the CSU, the CCG created an in-house Information Governance Team shared with Calderdale CCG, North Kirklees CCG, and Wakefield CCG. The new service is provided by an experienced team of experts offering advice and assistance on all areas of information governance.

It is a nationally mandated requirement that an organisation's information assets are risk assessed on an annual basis, but more importantly this process provides assurance to the Senior Information Risk Owner (SIRO) that information contained within the assets is secure

and that personal data is being processed in accordance with the Data Protection Act. The CCG has assigned Information Asset Owners to take on responsibility for information security of a range of business systems used by staff. The Information Asset Owners have completed a comprehensive review and risk assessment of their information assets to ensure that sufficient security measures and controls are in place to protect any area or system where business sensitive or person identifiable information is stored.

The CCG has made considerable progress to successfully embed information governance and information risk management processes within the organisation. This has been supported by results from staff awareness surveys, audits and spot checks. The CCG has continued to build on their achievement of an attainment level 2 or above in all requirements against Version 11 (2013/14) of the Information Governance Toolkit by improving overall assessment score from 70% (2013/14), to 94% (2014/15), to 95% in 2015/16.

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

The CCG has a range of processes in place to ensure that our resources are used economically, efficiently and effectively, and the Governing Body receives assurances to be able to determine that these processes are working well.

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

The Finance & Performance Committee and Governing Body receive detailed monthly finance and contracting reports setting out the financial position including associated risks. During the year an action plan was agreed by the Committee to manage increases in continuing care spend above the planned budget.

Internal Audit have responsibility for reviewing, appraising and reporting on the adequacy and application of financial controls. Internal Audit and External Audit representatives attend all meetings of the Audit Committee.

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

The CCG does not have any delegated chains at this moment in time.

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

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

Capacity to Handle Risk

I have set out within the section of the report entitled 'The Clinical Commissioning Group Risk Management Framework' 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.

During 2015/16, all risk owners and senior reviewers received additional support to review each of their risks with an expert from the former CSU Governance & 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 Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

The Board 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.

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

The formal process for maintaining and reviewing the effectiveness of the system of internal control is:

- Governing Body keeps under review the systems of internal control through reports on risk management and the assurance framework as well as the performance, contracting, finance and quality reports.
- At a committee level the **Finance and Performance and Quality and Safety Committees** take responsibility for keeping under review the governance arrangements relating to finance, contracting, performance and clinical governance.
- The **Audit Committee** has oversight of the CCG's financial systems, financial information, risk management, audit, information governance and business continuity.

- **Auditors** provide further assurance through the delivery of their annual work plan and providing assurance as well as recommendations on different aspects within the system of internal control.
- **Self-assessment** of the risk management system and committee governance arrangements undertaken on an annual basis.
- **Financial Control Environment** - The CCG completed a self-assessment of its financial control environment in August 2015. Each CCG was required to evaluate the strength of its financial governance and controls across a range of key areas. The completed assessment was reviewed by the Audit Committee and Governing Body and discussed with the CCG's internal auditors. The CCG reported 'Excellent' in two areas; 'Good' in 11 areas, 'Moderate' in 4 areas, and 'Not Applicable' in one area.
- **Third Party Assurance.** Alongside the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as the NHS Shared Business Services, Yorkshire and Humber Commissioning Support and Calderdale & Huddersfield NHS Foundation Trust (provider of payroll services). At the time of writing no significant issues have been reported although the formal assurance reports have not been received as yet.

During the year no significant internal control issues were raised.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

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

Roles and responsibilities

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

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

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

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

In accordance with the Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.
The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation. As such, it is one component that the Clinical Commissioning Group and Governing Body take into account in making its Governance Statement.

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

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

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

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

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

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

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

During 2015/16 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to be embedded.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. The design of the Assurance Framework has been kept under regular review since the creation of the CCG. The Governing Body retains oversight of the design and content the Assurance Framework. The Governing body reviewed the Assurance Framework on two occasions during the year end is next due

to review the Assurance Framework in May 2016. The Assurance Framework is subject to regular review by both the CCG's Audit committee.

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

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

The 2015/16 Internal Audit Plan was presented to the Audit Committee on 20 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 it's design and/or operation in core areas to effectively meet the organisation's objectives
LOW	Low assurance can be given as there is a weak system of internal control and significant improvement is required in its design and/or operation to effectively meet the organisation's objectives.

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

Internal Audit also supports the organisation when undergoing process design/redesign through the completion of advisory audit work. These audits are designed to provide advice as opposed to an assurance level during the development phase. Two advisory audits have been undertaken during 2015/16. These were in relation to a Risk Register Benchmarking exercise and a survey on Lead & Collaborative Commissioning.

Furthermore, it is noted that no overall assurance opinion has been provided in relation to the two Information Governance Toolkit audits completed during the year; however, it can be confirmed that adequate evidence was in place to support a level 2 attainment or above for all of the requirements sampled in relation to version 13 of the Toolkit (submitted by the CCG as at 31 March 2016).

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

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

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

Looking Ahead

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

At the Governing Body meeting in March 2016 the CCGs Governing Body was provided with an update that it was planned that the CCG would submit a 2016/17 financial plan with a break-even position. NHS England guidance sets out delivery of a minimum 1% surplus. There is a financial gap in the plan of £1.5m which needs to be closed through efficiencies which have not yet been identified.

HELEN KEMP TAYLOR
ACTING HEAD OF AUDIT
APRIL 2016

During the year, Internal Audit have not issued any audit reports with limited or no assurance which identified governance, risk management and/or control issues which were significant to the organisation.

Data Quality

The quality of data presented to the Committees and the Governing Body continues to evolve, and all Governing Body members confirmed, as part of the annual assessment process, that they received clear and concise information enabling them to make a decision or receive assurance on a matter.

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

The CCG has implemented systems to ensure that information security or data protection incidents are reported via the CCG's incident reporting system. Personal information incidents will typically breach one of the principles of the Data Protection Act and/or the Common Law Duty of Confidentiality.

Serious incidents are notified to the CCG's Senior Information Risk Owner (SIRO) and where applicable to the Caldicott Guardian. Risks arising through the investigation are logged in the CCG's risk registers, along with a note of actions to be taken to minimise the chances of occurrence and reduce impact.

We have had no personal data related incidents from 1 April 2015 to 24 May 2016.

We take a robust approach to reporting incidents, and we also log any personal data related incidents which are as a result of other organisations sending information into the CCG. In such circumstances, the CCG reports an incident and notifies the organisation from which the information originated.

During 2015/16, the CCG has had no serious incidents relating to data security breaches reported.

We have submitted a satisfactory level of compliance with the information governance toolkit assessment, as set out above.

Discharge of Statutory Functions

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

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

Responsibility for each duty and power has been clearly allocated to a lead Head of Service. Services have confirmed that their structures provide the necessary capability and capacity to undertake all of the Clinical Commissioning Group's statutory duties.

Conclusion

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

Carol McKenna
Accountable Officer

Date:

Committee Membership and Attendance Records – 1 April 2015 – 24 May 2016

Governing Body	Attendance
Dr Dil **Ashraf**, GP Practice Representative (until 30 September 2015)	83%
Dr Chris **Beith**, GP Practice Representative (from 1 October 2015)	100%
Irving **Cobden**, Secondary Care Advisor	64%
Dr Ramesh **Edara**, GP Practice Representative	82%
Dr Jane **Ford**, GP Practice Representative	82%
Tony **Gerrard**, Lay Member: Audit (until 30 March 2016)	71%
Dr Anuj **Handa**, GP Practice Representative	57%
Dr David **Hughes**, GP Practice Representative	64%
Dr Matthew **Kaye**, GP Practice Representative (from 1 October 2015)	93%
Julie **Lawreniuk**, Chief Finance Officer (until 28 April 2016)	85%
David **Longstaff**, Lay Member: Audit (from 1 April 2016)	100%
Priscilla **McGuire**, Lay Member: Patient and Public Involvement (from 1 April 2016)	100%
Carol **McKenna**, Chief Officer	100%
Angela **Monaghan**, Nurse Advisor	86%
Dr Steve **Ollerton**, Clinical Leader **(Chair)**	93%
Dr Judith **Parker**, GP Practice Representative (until 30 September 2015)	100%
Vanessa **Stirum**, Lay Member: Patient and Public Involvement (until 30 March 2016)	92%
Lesley **Stokey**, Acting Chief Finance Officer (from 29 April 2016)	100%
Penny **Woodhead**, Head of Quality & Safety	93%
Dr Maria **Wybrew**, GP Practice Representative (until 30 March 2016)	83%
Audit Committee	
Dr Ramesh **Edara**, GP Practice Representative (until 30 September 2015)	67%
Tony **Gerrard**, Lay Member: Audit (until 30 March 2016) **(Chair)**	83%
Dr Matthew **Kaye**, GP Practice Representative (from 1 October 2015)	100%
David **Longstaff**, Lay Member: Audit (from 1 April 2016) **(Chair)**	100%
Priscilla **McGuire**, Lay Member: Public and Patient Involvement (from 1 April 2016)	100%
Angela **Monaghan**, Nurse Advisor	86%
Vanessa **Stirum**, Lay Member: Public and Patient Involvement (until 30 March 2016)	100%
Finance & Performance Committee	
Dr Dil **Ashraf**, GP Practice Representative (until 30 September 2015)	100%
Dr Ramesh **Edara**, GP Practice Representative (from 1 October 2015 – 31 March 2016)	67%
Tony **Gerrard**, Lay Member: Audit (until 30 March 2016)	83%
Dr Matthew **Kaye**, GP Practice Representative (from 1 October 2015)	85%
Julie **Lawreniuk**, Chief Finance Officer (until 28 April 2016)	85%
David **Longstaff**, Lay Member: Audit (from 1 April 2016)	100%

Carol **McKenna**, Chief Officer (Chair)	85%
Dr Steve **Ollerton**, Clinical Leader	69%
Joint Commissioning Committee (until 30 March 2016)	
Wendy **Barker**, NHS England (from	100%
Irving **Cobden**, Secondary Care Advisor	63%
Kathryn **Hilliam**, NHS England	25%
Julie **Lawreniuk**, Chief Finance Officer	63%
Carol **McKenna**, Chief Officer	100%
Dr Steve **Ollerton**, Clinical Leader	100%
Geraldine **Sands**, NHS England (until	50%
Vanessa **Stirum**, Lay Member: Patient and Public Involvement **(Chair)**	88%
Dr Maria **Wybrew**, GP Practice Representative	50%
Primary Care Commissioning Committee (from 1 April 2016)	
Nigel **Bell**, Lay Advisor (from 1 May 2016)	0%
Irving **Cobden**, Secondary Care Advisor	50%
Dr Jane **Ford**, GP Practice Representative	100%
Julie **Lawreniuk**, Chief Finance Officer (until 28 April 2016)	100%
David **Longstaff**, Lay Member: Audit	100%
Priscilla **McGuire**, Lay Member: Patient and Public Involvement **(Chair)**	100%
Carol **McKenna**, Chief Officer	100%
Dr Steve **Ollerton**, Clinical Leader	100%
Lesley **Stokey**, Acting Chief Finance Officer (from 29 April 2016)	100%
Quality & Safety Committee	
Dr Chris **Beith**, GP Practice Representative (from 1 October 2015)	86%
Dr Jane **Ford**, GP Practice Representative **(Chair from 1 October 2015)**	85%
Dr Anuj **Handa**, GP Practice Representative (from 1 October 2015)	71%
Priscilla **McGuire**, Lay Member: Patient and Public Involvement (from 1 April 2016)	100%
Dr Judith **Parker**, GP Practice Representative **(Chair until 30 September 2015)**	83%
Vanessa **Stirum**, Lay Member: Patient and Public Involvement (until 30 March 2016)	75%
Penny **Woodhead**, Head of Quality & Safety	92%
Dr Maria **Wybrew**, GP Practice Representative (until 30 September 2015)	67%
Remuneration Committee	
Tony **Gerrard**, Lay Member: Audit **(Chair until 30 March 2016)**	100%
David **Longstaff**, Lay Member: Audit **(Chair from 1 April 2016)**	100%
Priscilla **McGuire**, Lay Member: Public and Patient Involvement (from 1 April 2016)	100%
Angela **Monaghan**, Nurse Advisor	83%
Vanessa **Stirum**, Lay Member: Public and Patient Involvement (until 30 March 2016)	80%

Remuneration and Staff Report

Membership of the Remuneration Committee

Details of the members of the Remuneration Committee can be found within the Governance Statement (page 71).

The Remuneration Committee is supported in its determinations by senior professionals who provide support and advice to the committee regarding their specialism. These professionals include a senior HR Professional from the HR service at Calderdale and Huddersfield Foundation Trust, the CCG Chief Finance Officer and the CCG Governance & Corporate Manager.

Remuneration Policy for Senior Managers

The definition of 'senior managers' is: *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. Such persons will include advisory or lay members.*

For the purpose of the Remuneration Report, all members of the Governing Body are deemed to be 'senior managers'.

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

Hutton review fair pay principles (2011):

- Remuneration should fairly reward each individual's contribution to their organisation's success and should be sufficient to recruit, retain and motivate executives of sufficient calibre. However, organisations should be mindful of the need to avoid paying more than is necessary in order to ensure value for money in the use of public resources;
- Remuneration must be set through a process that is based on a consistent framework and independent decision-making based on accurate assessments of the weight of roles and individuals' performance in them;
- Remuneration should be determined through a fair and transparent process via bodies that are independent of the executives whose pay is being set, and who are qualified or experienced in the field of remuneration. No individual should be involved in deciding his or her own pay;
- Remuneration must be based on the principle of equal pay for work of equal value.

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

- RSM Tenon – Technical Employment Status Guidance (2012)
- RSM Tenon FAQs

- Annex 2 of the April 2012 NHS Commissioning Board (NHS CB) publication "*Clinical Commissioning Group Governing Body members: Role outlines, attributes and skills*". This provides guidance on the principles relating to reimbursement and remuneration for governing body members.
- NHS Commissioning Board (now referred to as NHS England) "*Clinical Commissioning Groups – HR Frequently Asked Questions*" (June 2012) notes the importance of considering the employment status of all CCG posts in order to determine the correct contractual status under current legislation and HM Revenue & Customs (HMRC) rules;
- The NHS Confederation briefing "Deciding how to pay: remuneration for clinical commissioners" (June 2012)
- David Nicholson letter – Gateway Reference 17993 (August 2012)

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

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

For the **Registered Nurse and Secondary Care Specialist** posts on the Governing Body, remuneration should be either at a rate commensurate with their salary or as needed for replacement costs; or at a rate commensurate with the average rate for their profession and level of seniority.

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

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

For the **Accountable Officer and the Chief Finance Officer**, which are subject to VSM terms and conditions, consideration also took account of:

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

For the **Head of Quality & Safety**, this is driven by Agenda for Change.

This approach will be retained in respect of any new determinations for 2016/17.

Benchmarking Rates of Remuneration

The proposed remuneration for each of the categories of Governing Body member including the Chief Finance Officer, Accountable Officer and Head of Quality & Safety took into account

comparative data across CCGs, and recommended rates of remuneration for Chief Finance Officer and Accountable Officer.

Senior Manager pay is reviewed annually, however increases to pay have not been applied, with the exception of the Chief Officer. This is following a benchmarking exercise, which identified that the Accountable Officer's salary, which had not been reviewed since establishment of the CCG, was not in line with comparators in local CCGs. Therefore in order to ensure this key role is appropriately remunerated, a small increase was applied to this post.

Senior Managers Performance Related Pay

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

Policy on Senior Manager Contracts

The Accountable Officer, Chief Finance Officer, and Head of Quality & Safety are classed as senior managers as defined in the Annual Reporting Guidance. All have contracts of employment which set out their terms and conditions. The Chief Finance Officer is employed by Calderdale CCG and the remuneration for this post is determined by Calderdale CCG. These contracts are for permanent positions to ensure business continuity. For the Accountable Officer and Chief Finance Officer the notice period is six months.

Senior Manager Service Contracts

The CCG currently uses the following categories of terms of engagement for Governing Body members; Individual Agreement (Secondary Care Specialist); Contract of Employment for the GP Chair; Contract for Service for GP practice representatives, the Lay Members, and the Nurse Advisor.

As set out in the CCG's Standing Orders, the term of office of Practice Representatives (i.e. GPs including the Clinical Leader), Lay Members, the Secondary Care Specialist and the Registered Nurse is three years.

Payments to Past Senior Managers

No payment has been made to past senior managers.

Pay Multiples

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

The banded remuneration of the highest paid director/member of the Governing Body in the Clinical Commissioning Group in the financial year 2015-16 was £140k-145k (2014-15, £140k - £145k). This was 3.9 times (2014-15, 3.5 times) the median remuneration of the workforce, which was £35,891 (2014-15, £40,558).

In 2015-16, no employees received remuneration in excess of the highest-paid member of the Membership Body/Governing Body. Remuneration ranged from £16,633 to £141,250 (2014-15 £16,271-£141,250)

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

The change to the median remuneration of the workforce is due to the closedown of the Yorkshire & Humber Commissioning Support (CSU) and the in-housing of a number of services previously provided by the CSU.

Off Payroll Engagements

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

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

	Number
Number of existing engagements as of 31 March 2016	5
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	2
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

	Number
Number of new engagements, or those that reached six months in duration, between 1st April 2015 and 31 March 2016	1
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.	0
Number for whom assurance has been requested	5
Of which, the number:	
For whom assurance has been received	3
For whom assurance has not been received	2
That have been terminated as a result of assurance not being received	0

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

Salaries and Allowances

Name & Title		2014-15 Staff in Pos	2014-15					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term Performance pay and bonuses	All Pension related Benefit (Note 3)	Total
			(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
			£000	£000	£000	£000	£000	£000
Dr Stephen Ollerton	Clinical Leader	01/04/2014 to 31/03/2015	90 - 95				152.5 - 155.0	240 - 245
Dr Judith Parker	Deputy Clinical Leader	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Dr Dilshad Ashraf	Practice Representative	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Dr Maria Wybrew	Practice Representative	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Dr Jane Ford	Practice Representative	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Dr Anuj Handa	Practice Representative	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Dr David Hughes	Practice Representative	01/04/2014 to 31/03/2015	30 - 35					30 - 35
Dr Ramesh Edara	Practice Representative	01/04/2014 to 31/03/2015	45 - 50					45 - 50
Tony Gerrard	Audit Lay Member	01/04/2014 to 31/03/2015	5 - 10					5 - 10
Vanessa Stirum	Patient and Public Involvement Lay Member	01/04/2014 to 31/03/2015	5 - 10					5 - 10
Dr Irving Cobden	Secondary Care Advisor	01/04/2014 to 31/03/2015	20 - 25					20 - 25
Angela Monaghan	Nurse Advisor	01/04/2014 to 31/03/2015	5 - 10					5 - 10
Carol McKenna	Chief Officer	01/04/2014 to 31/03/2015	110 - 115				12.5 - 15	125 - 130
Julie Lawreniuk	Chief Finance Officer **(Note 1)**	01/04/2014 to 31/03/2015	50 - 55				10 - 12.5	60 - 65
Penny Woodhead	Head of Quality and Safety **(Note 2)**	01/04/2014 to 31/03/2015	35 - 40					35 - 40

Name & Title		2015-16 Staff in Pos	2015-16					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term Performance pay and bonuses	All Pension Related Benefit (Note 3)	Total
			(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
			£000	£000	£000	£000	£000	£000
Dr Stephen Ollerton	Clinical Leader	01/04/2015 to 31/03/2016	85 - 90				30 - 32.5	115 - 120
Dr Judith Parker	Deputy Clinical Leader	01/04/2015 to 30/09/2015	20 - 25					20 - 25
Dr Dilshad Ashraf	Practice Representative	01/04/2015 to 30/09/2015	20 - 25					20 - 25
Dr Maria Wybrew	Practice Representative	01/04/2015 to 31/03/2016	40 - 45					40 - 45
Dr Jane Ford	Practice Representative	01/04/2015 to 31/03/2016	45 - 50					45 - 50
Dr Anuj Handa	Practice Representative	01/04/2015 to 31/03/2016	45 - 50					45 - 50
Dr David Hughes	Practice Representative	01/04/2015 to 31/03/2016	30 - 35					30 - 35
Dr Ramesh Edara	Practice Representative	01/04/2015 to 31/03/2016	45 - 50					45 - 50
Dr Matthew Kaye	Practice Representative	01/10/2015 to 31/03/2016	20 - 25					20 - 25
Dr Chris Beith	Practice Representative	01/10/2015 to 31/03/2016	20 - 25					20 - 25
Tony Gerrard	Audit Lay Member	01/04/2015 to 31/03/2016	10 - 15					10 - 15
Vanessa Stirum	Patient and Public Involvement Lay Member	01/04/2015 to 31/03/2016	10 - 15					10 - 15
Dr Irving Cobden	Secondary Care Advisor	01/04/2015 to 31/03/2016	15 - 20					15 - 20
Angela Monaghan	Nurse Advisor	01/04/2015 to 31/03/2016	10 - 15					10 - 15
Carol McKenna	Chief Officer	01/04/2015 to 31/03/2016	120 - 125				67.5 - 70	190 - 195
Julie Lawreniuk	Chief Finance Officer **(Note 1)**	01/04/2015 to 31/03/2016	50 - 55				35 - 37.5	90 - 95
Penny Woodhead	Head of Quality and Safety **(Note 2)**	01/04/2015 to 31/03/2016	35 - 40					35 - 40

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

Note 2: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG, for whom she is also Head of Quality. Her total salary is in the banding £70k - 75k, however, only 50% has been included in the Salary & Fees column.

Note 3: Dr Jane Ford has received payments of £15k for the period 01 April 2015 to 31 March 2016 for the additional clinical work undertaken in the CCG which is separate from her role as a Governing Body member

Note 4: The amounts included in All Pension Related Benefits is the annual increase in pension entitlement determined in accordance with the 'HMRC' method.

The increase = ((20 x PE) +LSE) - ((20 x PB) + LSB)

• Where:

• PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;

• PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;

• LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year; and

• LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

Pension Benefits

Name & Title		2015-16 Staff in Post	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 1 April 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Employer's contribution to partnership pension £000
			2015-16							
Dr Stephen Ollerton	Clinical Leader	01/04/2013 to 31/03/2014	0 - 2.5	- 2.5 - 0	10 - 15	25 - 30	123	11	138	8
Carol McKenna	Chief Officer	01/04/2014 to 31/03/2015	2.5 - 5	0 - 2.5	35 - 40	100 - 105	551	45	603	31
Julie Lawreniuk	Chief Finance Officer	01/04/2014 to 31/03/2015	0 - 2.5	2.5 - 5	30 - 35	100 - 105	610	36	654	25

Note 1: Julie Lawreniuk is employed by Calderdale CCG but is a shared post also with Greater Huddersfield CCG, for whom she is also Chief Financial Officer. The above info includes the full pension information, not a proportion.

Note 2: NHS Pensions Agency has stated that they cannot provide pension benefits information for Governing Body GPs who are classed only as practitioners with NHS Pensions Agency, and also where they have a contract for service with the CCG. As a result the CCG is not able to show the pension benefits related to their role as a governing body member. The CCG pays over the pension contributions to NHS England who act as the NHS Pension Employing Authority for these GPs.

Carol McKenna
Accountable Officer

Date:

Staff Report

Number of Senior Managers by Band

As set out in the Remuneration Report, all members of the Governing Body are deemed to be 'senior managers'. The Governing Body membership and remuneration is set out within the Remuneration Report.

Staff Numbers (average number of employees)

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	63	45	18	54
Of the above: Number of whole time equivalent people engaged on capital projects	0	0	0	0

Staff Composition

Gender Profile of the CCG

	Headcount	
	Male	Female
Members of the Governing Body (this includes all senior managers)	8	6
All other employees not included above	17	56

Age Profile of the CCG (excluding Governing Body)

Age Range	Headcount
20-25	3
26-30	2
31-35	7
36-40	15
41-45	12
46-50	11
51-55	18
56-60	8

Ethnicity of the CCG's Staff (excluding Governing Body)

Ethnicity	Headcount
White	60
Asian/Asian British	11
Black/Black British	2
Other	1
Not Stated	2

Sickness Absence Data

	2015-16 Number	2014-15 Number
Total Days Lost	278	203
Total Staff Years	56	47
Average working Days Lost	5	4

Greater Huddersfield CCG has a real interest in developing the health and wellbeing agenda to ensure a healthy working environment for all colleagues. The CCG has policies and procedures in place to support colleagues with sickness absence and is keen to develop a positive and pro- active approach to supporting colleagues through sickness absence or difficult periods in their lives. During 2015, the CCG introduced an Employee Assistance Programme (EAP) to further support the needs of the workforce. This service provides confidential advice and counselling support to staff, which the CCG views as being important to support the health and wellbeing of staff.

Staff Policies in Relation to Disabled Persons

We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments for our disabled employees and those who become disabled during the course of their employment. We do this on an individual basis and involve occupational health services as appropriate. The principle of reasonable adjustment is embedded throughout all policies as described above and the CCG's commitment to disabled people is covered in a number of policies and procedures which are available to all staff through the intranet. In particular those outlined below:

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

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

The CCG invested a significant amount of time into securing the "Two Ticks" award - positive about disabled people. This was awarded to the CCG by Job Centre Plus and allows us to use the logo which

shows disabled people that we have made the following commitments regarding recruitment, training, retention, consultation and disability awareness:

- ✓ To interview all disabled applicants who meet the minimum criteria for a job and to consider them on their abilities.
- ✓ To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities.
- ✓ To make every effort when employed become disabled to make sure that they stay in employment.
- ✓ To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work.
- ✓ To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and job centre plus know about progress and future plans.

This award was initially granted in 2013/14. Job Centre Plus has undertaken a review of the practices across the CCG and the CCG was successful in retaining this award in 2015. At the time of writing, the CCG is in the process of undergoing a review, and it is expected that the CCG will retain the award in 2016.

Expenditure on Consultancy

In 2015/16, the CCG has spent £45k on consultancy fees.

Off Payroll Engagements

Please see page 75 of the Remuneration Report.

Exit Packages

The CCG has had no compulsory redundancies, other agreed departures or departures where payments have been made.

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Accounts 2015/16

FOREWORD TO THE ACCOUNTS

GREATER HUDDERSFIELD CCG

These accounts for the year ended 31 March 2016 have been prepared by
Greater Huddersfield CCG under the Health and Social Care Act 2012
in the form which the Secretary of State has, with the approval of the Treasury, directed.

NHS Greater Huddersfield CCG - Annual Accounts 2015-16

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The Primary Statements:

NHS Greater Huddersfield CCG - Annual Accounts 2015-16

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	3,609	3,135
Operating Expenses	5	290,154	284,892
Other operating revenue	2	(3,876)	(4,739)
Net operating expenditure before interest		**289,887**	**283,288**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**289,887**	**283,288**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**289,887**	**283,288**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	2,662	2,296
Operating Expenses	5	3,081	3,711
Other operating revenue	2	(436)	(437)
Net administration costs before interest		**5,307**	**5,570**
Programme Income and Expenditure			
Employee benefits	4.1.1	947	839
Operating Expenses	5	287,073	281,181
Other operating revenue	2	(3,440)	(4,302)
Net programme expenditure before interest		**284,580**	**277,718**

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		**289,887**	**283,288**

The notes on pages 92 to 120 form part of this statement

NHS Greater Huddersfield CCG - Annual Accounts 2015-16

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	13	99	117
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		99	117
Current assets:			
Inventories	16	951	386
Trade and other receivables	17	1,671	786
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	30	14
Total current assets		**2,652**	1,186
Non-current assets held for sale	21	0	0
Total current assets		**2,652**	1,186
Total assets		**2,751**	1,303
Current liabilities			
Trade and other payables	23	(15,381)	(14,519)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(15,381)**	(14,519)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(12,630)**	(13,216)
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		**(12,630)**	(13,216)
Financed by Taxpayers' Equity			
General fund		(12,630)	(13,216)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(12,630)**	(13,216)

The notes on pages 92 to 120 form part of this statement

The financial statements on pages 88 to 91 were approved by the Audit Committee on 18 May 2016 and signed on its behalf by:

Chief Accountable Officer
Carol McKenna

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(13,216)	0	0	**(13,216)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(13,216)**	**0**	**0**	**(13,216)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(289,887)			(289,887)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(289,887)**	**0**	**0**	**(289,887)**
Net funding	290,473	0	0	290,473
Balance at 31 March 2016	**(12,630)**	**0**	**0**	**(12,630)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(13,586)**	**0**	**0**	**(13,586)**
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	**(13,586)**	**0**	**0**	**(13,586)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs for the financial year	(283,288)			(283,288)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning Board Expenditure for the Financial Year	**(283,288)**	**0**	**0**	**(283,288)**
Net funding	283,658	0	0	283,658
Balance at 31 March 2015	**(13,216)**	**0**	**0**	**(13,216)**

The notes on pages 88 to 91 form part of this statement

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		(289,887)	(283,288)
Depreciation and amortisation	5	55	50
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	16	(565)	(276)
(Increase)/decrease in trade & other receivables	17	(886)	259
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	873	(447)
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		**(290,410)**	(283,702)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(47)	(3)
(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		**(47)**	(3)
Net Cash Inflow (Outflow) before Financing		**(290,457)**	(283,705)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		290,473	283,658
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		**290,473**	283,658
Net Increase (Decrease) in Cash & Cash Equivalents	20	**16**	(47)
Cash & Cash Equivalents at the Beginning of the Financial Year		**14**	61
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**30**	14

The notes on pages 88 to 91 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**

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 **Pooled Budgets**

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

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

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

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

1.7 **Critical Accounting Judgements & Key Sources of Estimation Uncertainty**

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

1.7.1 ***Critical Judgements in Applying Accounting Policies***

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

1.7.2 **Key Sources of Estimation Uncertainty**

The CCG has made no key estimations during the period.

Notes to the financial statements

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,

Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,

Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.11.2 **Valuation**

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

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

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

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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**

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

1.15 **Government Grants**

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

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

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

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

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

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

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

1.17 **Leases**

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

Notes to the financial statements

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

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

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

1.18 **Private Finance Initiative Transactions**

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

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

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

1.18.1 **Services Received**

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

1.18.2 **PFI Asset**

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 **PFI Liability**

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 **Lifecycle Replacement**

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 **Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme**

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

1.18.6 **Other Assets Contributed by the Clinical Commissioning Group to the Operator**

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

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

On initial recognition of the asset, an equivalent deferred income balance is recognised, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

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**

Notes to the financial statements

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

1.25 **Carbon Reduction Commitment Scheme**

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

1.26 **Contingencies**

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

Notes to the financial statements

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

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

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

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

1.27.4 **Loans & Receivables**

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

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

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

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

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

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

1.28 **Financial Liabilities**

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

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

Notes to the financial statements

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

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

1.33 **Subsidiaries**

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

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

1.34 **Associates**

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

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

1.35 **Joint Ventures**

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

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

1.36 **Joint Operations**

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

1.37 **Research & Development**

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	530	357	173	530
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	3	3	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	3,024	71	2,954	4,018
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	319	5	314	191
Total other operating revenue	**3,876**	**436**	**3,440**	**4,739**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	3,876	436	3,440	4,739
From sale of goods	0	0	0	0
Total	**3,876**	**436**	**3,440**	**4,739**

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	3,024	2,173	851	2,235	1,715	520	789	457	331
Social security costs	233	186	48	169	147	22	64	39	25
Employer Contributions to NHS Pension scheme	352	283	69	257	226	31	95	57	38
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	**3,609**	**2,641**	**968**	**2,662**	**2,088**	**574**	**947**	**553**	**394**
Less recoveries in respect of employee benefits (note 4.1.2)	(530)	(530)	0	(357)	(357)	0	(173)	(173)	0
Total - Net admin employee benefits including capitalised costs	**3,080**	**2,112**	**968**	**2,305**	**1,732**	**574**	**774**	**380**	**394**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,080**	**2,112**	**968**	**2,305**	**1,732**	**574**	**774**	**380**	**394**

4.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	2,613	1,921	692	1,919	1,472	447	694	449	245
Social security costs	207	165	42	151	128	23	56	37	19
Employer Contributions to NHS Pension scheme	315	253	62	226	192	34	89	61	28
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	**3,135**	**2,339**	**796**	**2,296**	**1,792**	**504**	**839**	**547**	**292**
Less recoveries in respect of employee benefits (note 4.1.2)	(530)	(530)	0	(345)	(345)	0	(185)	(185)	0
Total - Net admin employee benefits including capitalised costs	**2,605**	**1,809**	**796**	**1,951**	**1,447**	**504**	**654**	**362**	**292**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,605**	**1,809**	**796**	**1,951**	**1,447**	**504**	**654**	**362**	**292**

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	(439)	(439)	0	(437)
Social security costs	(39)	(39)	0	(38)
Employer contributions to the NHS Pension Scheme	(51)	(51)	0	(55)
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	**(530)**	**(530)**	**0**	**(530)**

4.2 Average number of people employed

	Total Number	2015-16 Permanently employed Number	Other Number	2014-15 Total Number
Total	**63**	**45**	**18**	54
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	278	203
Total Staff Years	56	47
Average working Days Lost	**5**	**4**

	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

4.4 Exit packages agreed in the financial year

The clinical commissioning group has had no compulsory redundancies, other agreed departures or departures where payments have been made.

4.5 Pension costs

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant 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 contribution rates payable by

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.

4.6 Severance Payments

The clinical commissioning group has had no severance payments in the year.

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	3,309	2,362	947	2,846
Executive governing body members	300	300	0	289
Total gross employee benefits	**3,609**	**2,662**	**947**	**3,135**
Other costs				
Services from other CCGs and NHS England	3,898 ***	1,697	2,201	3,692
Services from foundation trusts	154,293	69	154,224	160,083
Services from other NHS trusts	21,132	0	21,132	20,814
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	67,739	0	67,739	59,305
Chair and Non Executive Members	544	544	0	564
Supplies and services – clinical	(7)	0	(7)	12
Supplies and services – general	246	158	88	218
Consultancy services	45	41	4	0
Establishment	182	142	40	105
Transport	5	4	1	0
Premises	2,593	240	2,353	2,684
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	55	55	0	50
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	59	59	0	71
Other non statutory audit expenditure				
· Internal audit services	0 **	0	0	0
· Other services	10	10	0	(9)
General dental services and personal dental services	0	0	0	0
Prescribing costs	37,708	0	37,708	35,822
Pharmaceutical services	0	0	0	0
General ophthalmic services	122	0	122	133
GPMS/APMS and PCTMS	326	(24)	350	858
Other professional fees excl. audit	10	10	0	17
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	0	0	0	0
Education and training	79	75	3	73
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies		0	0	0
CHC Risk Pool contributions	1,115	0	1,115	400
Other expenditure	0	0	0	0
Total other costs	**290,154**	**3,081**	**287,073**	**284,892**
Total operating expenses	**293,763**	**5,743**	**288,020**	**288,027**

* 2014-15 acounts have been reclassified by moving £26.2m of continuing healthcare recharges from North Kirklees CCG have been moved from Services form CCG's and NHS England into Purchase of Healthcare from Non NHS Bodies

** Internal Audit services of £35k for 2015-16 and £35k for 2014-15 have been provided by Calderdale & Huddersfield Foundation Trust are included in Services from Foundation Trusts

*** Included in Services from CCG's and NHS England in 2015-16 is £1,181k of payments made by Calderdale CCG on behalf of Greater Huddersfield CCG for the work of the systems resilince group across Calderdale and Huddersfield

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	3,027	476	2,518	38,021
Total Non-NHS Trade Invoices paid within target	2,916	475	2,373	37,680
Percentage of Non-NHS Trade invoices paid within target	**96.33%**	**99.77%**	**94.24%**	**99.10%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,497	206	2,525	213,100
Total NHS Trade Invoices Paid within target	2,450	204	2,242	207,506
Percentage of NHS Trade Invoices paid within target	**98.12%**	**99.04%**	**88.79%**	**97.37%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The clinical commissioning group does not undertake any income generation activities.

8. Investment revenue

The clinical commissioning group has no investment revenue during the period.

9. Other gains and losses

The clinical commissioning group has no other gains and losses.

10. Finance costs

The clinical commissioning group has no finance costs during the period.

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

The clinical commissioning group has no net gains or losses on transfers during the period.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense								
Minimum lease payments	0	2,646	(0)	**2,646**	0	2,633	0	**2,633**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**2,646**	**(0)**	**2,646**	**0**	**2,633**	**0**	**2,633**

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	0	0	**0**	0	-	-	**0**
Between one and five years	0	0	0	**0**	0	-	-	**0**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd.
The annual rent charge is reflected in Note 12.1.1.
While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.

12.2 As lessor

The clinical commissioning group has no operating lease income during the period.

13 Property, plant and equipment

2015-16	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01-April-2015	0	0	0	0	0	0	78	139	217
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	37	0	37
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**115**	**139**	**254**
Depreciation 01-April-2015	0	0	0	0	0	0	44	56	100
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	27	28	55
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**71**	**83**	**155**
Net Book Value at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**44**	**56**	**99**
Purchased	0	0	0	0	0	0	44	56	99
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**44**	**56**	**99**
Asset financing:									
Owned	0	0	0	0	0	0	44	56	99
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**44**	**56**	**99**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 01-April-2015	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The clinical commissioning group has no assets under construction as at 31st March 2016.

13.2 Donated assets

The clinical commissioning group has no donated assets as at 31st March 2016.

13.3 Government granted assets

The clinical commissioning group has no government granted assets as at 31st March 2016.

13.4 Property revaluation

The clinical commissioning group has had no property revaluations during the period.

13.5 Compensation from third parties

The clinical commissioning group has not received any compensation from third parties for assets impaired during the period.

13.6 Write downs to recoverable amount

No assets have been written down to recoverable amounts during the period.

13.7 Temporarily idle assets

The clinical commissioning group has no temporarily idle assets as at 31st March 2016.

13.8 Cost or valuation of fully depreciated assets

None of the clinical commissioning groups assets are fully depreciated as at 31st March 2016.

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	3	3
Furniture & fittings	5	5

14 Intangible non-current assets

The clinical commissioning group has no intangible non-current assets brought forward, acquired or disposed of during the period.

15 Investment property

The clinical commissioning group had no investment property as at 31 March 2016.

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	386	386
Additions	0	0	0	0	0	565	565
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 other public sector body	0	0	0	0	0	0	0
At 31-March-2016	**0**	**0**	**0**	**0**	**0**	**951**	**951**

These inventories are for community equipment.

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	1,023	0	261	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	215	0	0 *	0
NHS accrued income	69	0	51 *	0
Non-NHS receivables: Revenue	143	0	339	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	75	0	30 *	0
Non-NHS accrued income	146	0	89 *	0
Provision for the impairment of receivables	0	0	0	0
VAT	0	0	16	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**1,671**	**0**	**786**	**0**
Total current and non current	**1,671**		**786**	
Included above:				
Prepaid pensions contributions	**0**		**0**	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

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

17.1 Receivables past their due date but not impaired	2015-16 £000	2014-15 £000
By up to three months	3	179
By three to six months	0	21
By more than six months	0	0
Total	**3**	**200**

All of the £3k above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2016.

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

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2016.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2016.

20 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	14	61
Net change in year	16	(47)
Balance at 31-March-2016	**30**	**14**
Made up of:		
Cash with the Government Banking Service	30	14
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**30**	**14**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**30**	**14**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

The clinical commissioning group does not have any non-current assets held for sale either brought forward or during the period.

22 Analysis of impairments and reversals

The clinical commissioning group has had no impairment or reversal of impairments on any of its assets during the period.

23 Trade and other payables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,216	0	1,067	0
NHS payables: capital	0	0	10	0
NHS accruals	1,964	0	5,081 *	0
NHS deferred income	0	0	0 *	0
Non-NHS payables: revenue	1,487	0	726	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	10,196	0	7,134 *	0
Non-NHS deferred income	46	0	0 *	0
Social security costs	39	0	0	0
VAT	0	0	0	0
Tax	39	0	0	0
Payments received on account	0	0	0	0
Other payables	394	0	500	0
Total Trade & Other Payables	**15,381**	**0**	**14,518**	**0**
Total current and non-current	**15,381**		**14,518**	

Other payables include £49k outstanding pension contributions at 31 March 2016

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

24 Other financial liabilities

The clinical commissioning group has no other financial liabilities as at 31st March 2016.

25 Other liabilities

The clinical commissioning group has no other liabilities as at 31st March 2016.

26 Borrowings

The clinical commissioning group has no borrowings as at 31st March 2016.

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group has no private finance initiative, LIFT or other service concession arrangements.

28 Finance lease obligations

The clinical commissioning group has no finance lease obligations as at 31st March 2016.

29 Finance lease receivables

The clinical commissioning group has no finance leases receivable as at 31st March 2016.

30 Provisions

	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Restructuring	Redundancy	Agenda for Change	Equal Pay	Legal Claims	Continuing Care	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 01-April-2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Arising during the year	0	0	0	0	0	0	0	0	0	0
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	0	0	0
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provision accounted for by NHS England on behalf of Greater Huddersfield CCG at 31 March 2016 is £1,595k.

31 Contingencies

The clinical commissioning group has no contingent liabilities or assets.

32 Commitments

32.1 Capital commitments

The clinical commissioning group has no outstanding capital commitments as at 31st March 2016.

32.2 Other financial commitments

The NHS Clinical Commissioning Group has not entered into any non-cancellable contracts.

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 the 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

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

33.1.1 Currency risk

The 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 clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the clinical commissioning group's revenue comes parliamentary funding, the 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

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The 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	1,093	0	1,093
· Non-NHS	0	288	0	288
Cash at bank and in hand	0	30	0	30
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**1,411**	**0**	**1,411**

	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	261	0	261
· Non-NHS	0	339	0	339
Cash at bank and in hand	0	14	0	14
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**614**	**0**	**614**

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	3,180	3,180
· Non-NHS	0	12,078	12,078
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**	**15,258**	**15,258**

	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	6,158	6,158
· Non-NHS	0	8,360	8,360
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**	**14,518**	**14,518**

33.4 Maturity of financial liabilities

The clinical commissioning group has a financial liability of £15,092k as at the 31st March 2016. All of this liability will be settled within the financial year ending 31st March 2017.

33.5 The entity's exposure to risk

The clinical commissioning group does not have any significant exposure to credit risk as at 31st March 2016.

34 Operating segments

The clinical commissioning group and consolidated group consider they have only one segment: commissioning of healthcare services.

34.1 Reconciliation between Operating Segments and SoCNE

	2015-16 £'000	2014-15 £'000
Total net expenditure reported for operating segments	289,887	283,288
Reconciling items:	0	0
	289,887	283,288

34.2 Reconciliation between Operating Segments and SoFP

	2015-16 £'000	2014-15 £'000
Total assets reported for operating segments	2,751	1,303
Reconciling items:	0	0
Total assets per Statement of Financial Position	2,751	1,303

	2015-16 £'000	2014-15 £'000
Total liabilities reported for operating segments	(15,381)	(14,518)
Reconciling items:	0	0
Total liabilities per Statement of Financial Position	(15,381)	(14,518)

35 Pooled budgets

35.1 Community Equipment Service

Greater Huddersfield Clinical Commissioning Group has entered into a pooled budget for Community Equipment Service with North Kirklees 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.

The clinical commissioning group's and consolidated group's shares of the income and expenditure handled by the pooled budget in the financial year were:

	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)**

35.2 Better Care Fund

On 1st April 2015 Greater Huddersfield Clinical Commissioning Group has entered into a pooled budget arrangememt for Better Care Fund with North Kirklees 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 the financial year were:

	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	
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**
	0	**0**

As at 31st March 2016 Greater Huddersfield CCG have included £124k creditors and £317k accruals for Better Care Fund

36 NHS Lift investments

The clinical commissioning group has no NHS LIFT investments.

37 Intra-government and other balances

	Current Receivables 2015-16 £000	Non-current Receivables 2015-16 £000	Current Payables 2015-16 £000	Non-current Payables 2015-16 £000
Balances with:				
· Other Central Government bodies	0	0	0	0
· Local Authorities	149	0	237	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	6	0
· NHS bodies within the NHS England Group	1,069	0	226	0
· NHS Trusts and Foundation Trusts	238	0	2,948	0
Total of balances with NHS bodies:	**1,307**	**0**	**3,180**	**0**
· Public corporations and trading funds	215	0	11,964	0
· Bodies external to Government	0	0	0	0
Total balances at 31-March-2016	**1,671**	**0**	**15,381**	**0**

	Current Receivables 2014-15 £000	Non-current Receivables 2014-15 £000	Current Payables 2014-15 £000	Non-current Payables 2014-15 £000
Balances with:				
· Other Central Government bodies	0	0	18	0
· Local Authorities	0	0	475	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	0	0	0	0
· NHS bodies within the NHS England Group	79	0	3,032	0
· NHS Trusts and Foundation Trusts	233	0	3,126	0
Total of balances with NHS bodies:	**312**	**0**	**6,158**	**0**
· Public corporations and trading funds	474	0	7,867	0
· Bodies external to Government	0	0	0	0
Total balances at 31-March-2015	**786**	**0**	**14,518**	**0**

38 Related party transactions

Representatives from the GP practices below were members of our Governing Body during 2014/15 and/or 2013/14. Their practices received remuneration from the CCG for services to patients. The amounts involved are disclosed below. The remuneration of individual Executive Governing Body members is disclosed within the CCG's Remuneration Report section of the Annual Report.

Details of related party transactions with individuals are as follows:

	Payments to Related Party 2015/16 £000	Receipts from Related Party 2015/16 £000	Amounts owed to Related Party 2015/16 £000	Amounts due from Related Party 2015/16 £000	Payments to Related Party 2014/15 £000	Receipts from Related Party 2014/15 £000	Amounts owed to Related Party 2014/15 £000	Amounts due from Related Party 2014/15 £000
Elmwood (Dr David Hughes)	138	0	10	0	189	0	26	0
Colne Valley (Dr Ramesh Edara)	67	0	12	0	54	0	10	0
Lindley Group (Dr Matt Kaye)	116	0	10	0				
The Grange (Dr Jane Ford)	147	0	8	0	161	0	19	0
Meltham Group (Dr Dil Ashraf)	80	0	2	0	57	0	12	0
Skelmanthorpe (Dr Steve Ollerton)	93	0	4	0	83	0	12	0
Fartown (Dr Anuj Handa)	15	0	2	0	18	0	8	0
Netherton (Dr Chris Beith)	57	0	9	0				
Lindley Group (Dr Judith Parker)	116	0	10	0	88	0	13	0
Drs Wybrew (Dr Maria Wybrew)	37	0	2	0	45	0	8	0

The parent entity for the CCG is NHS England. The Department of Health 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. For example:

	2015/16 £000	2014/15 £000
Calderdale & Huddersfield NHS Foundation Trust	121,159	126,573
Prescription Pricing Authority	36,615	34,479
South West Yorkshire Partnership NHS Foundation Trust	23,189	24,286
Yorkshire Ambulance Service NHS Trust	11,663	11,611
Leeds Teaching Hospitals NHS Trust	6,672	6,386
Barnsley Hospital NHS Foundation Trust	3,660	3,490
Bradford Teaching Hospitals NHS Foundation Trust	2,667	2,744
NHS Property Services	2,647	2,633
NHS Yorkshire & The Humber CSU	2,208	2,632
Mid Yorkshire Hospitals NHS Trust	2,082	2,178
NHS Calderdale CCG	1,551	434
NHS England	1,117	555
Sheffield Teaching Hospitals NHS Foundation Trust	899	957
NHS North Kirklees CCG	856	27,578

Julie Lawreniuk is the Chief Finance Officer of both Greater Huddersfield CCG and Calderdale CCG, but has no material transactions with either organisations.
Tony Gerrard is the Audit Lay Member for both Greater Huddersfield CCG and North Kirklees CCG, but has no material transactions.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Kirklees Metropolitan Council in respect of joint enterprises.

	2015/16 £000	2014/15 £000
Kirklees Metropolitan Council	9,546	2,914

39 Events after the end of the reporting period

From 1st April 2016, Greater Huddersfield CCG has been delegated responsibility for commissioning Primary Medical Services from NHS England. The expected budget to be delegated is approximately £31.7m.

40 Losses and special payments

The clinical commissioning group has incurred no losses or made any special payments in the year ending 31st March 2016.

40.1 Losses

The total number of NHS Clinical Commissioning Group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	0	0	0	0
Fruitless payments	0	0	0	0
Store losses	0	0	0	0
Book Keeping Losses	0	0	0	0
Constructive loss	0	0	0	0
Cash losses	0	0	0	0
Claims abandoned	0	0	0	0
Total	**0**	**0**	**0**	**0**

40.2 Special payments

	Total Number of Cases 2015-16 Number	**Total Value of Cases 2015-16 £'000**	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Compensation payments	0	0	0	0
Extra contractual Payments	0	0	0	0
Ex gratia payments	0	0	0	0
Extra statutory extra regulatory payments	0	0	0	0
Special severance payments	0	0	0	0
Total	**0**	**0**	**0**	**0**

41 Third party assets

The clinical commissioning group does not hold any cash or cash equivalents on behalf of other parties.

42 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	2015-16 Target	**2015-16 Performance**	**2015-16 Duty Achieved**	2014-15 Target	2014-15 Performance	2014-15 Duty Achieved
Expenditure not to exceed income	296,740	293,800	Yes	292,322	288,027	Yes
Capital resource use does not exceed the amount specified in	39	37	Yes	13	13	Yes
Revenue resource use does not exceed the amount specified in	292,825	289,887	Yes	287,583	283,288	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	5,550	5,307	Yes	6,914	5,570	Yes

The clinical commissioning group received revenue resource allocations totalling £292,825k and had net expenditure of £289,887k, delivering a surplus of £2,938k.

43 Impact of IFRS

The adoption of IFRS standards has no financial impact on the clinical commissioning group annual accounts.

44 Analysis of charitable reserves

The clinical commissioning group has no charitable reserves.

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF GREATER HUDDERSFIELD CCG

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

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

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2016 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting polices directed by the NHS Commissioning Board with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve

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

- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Certificate

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

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

Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

25 May 2016

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INDEPENDENT AUDITOR'S STATEMENT TO THE MEMBERS OF THE GOVERNING BODY OF GREATER HUDDERSFIELD CCG ON THE CCG ACCOUNTS CONSOLIDATION TEMPLATE

We have examined the Accounts Consolidation Template of Greater Huddersfield CCG for the year ended 31 March 2016.

This statement is made solely to the Members of the Governing Body of Greater Huddersfield CCG in accordance with Part 5 paragraph 20(5) of the Local Audit and Accountability Act 2014 and paragraph 4.2 of the Code of Audit Practice and for no other purpose.

For the purpose of this statement, reviewing the consistency of figures between the audited financial statements and the Accounts Consolidation Template extends only to those figures within the audited financial statements which are also published in the Accounts Consolidation Template.

Auditors are required to report on any differences over £250,000 between the audited financial statements and the Accounts Consolidation Template.

The figures reported in the Accounts Consolidation Template are consistent with the audited financial statements, on which we have issued an unqualified opinion.

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

Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

25 May 2016