FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: Thursday 29 June 2017

TITLE OF PAPER: North Kirklees CCG Annual Report and Accounts 2016/17

1. Purpose of paper

The North Kirklees CCG Annual Report and Accounts 16/17 is presented to the Kirklees Health and Wellbeing Board as a statutory responsibility of the Board, for information and awareness about the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year. And to provide assurance to Health and Wellbeing Board members that North Kirklees Performance supports the Kirklees wide Health and Wellbeing agenda.

2. Background

- Report has been approved by SMT and Governing Body
- External and internal Audit have considered and approved. The report has been approved by Audit Committee
- The Annual Report and Accounts have been signed off and published on the NKCCG website
- The signed version of the Annual Report and Accounts has been submitted to NHS England

3. Proposal

That the Health and Wellbeing Board endorse and support the NKCCG Annual Report and Accounts 2016/17 and comment on the extent to which the CCG has contributed to the delivery of the Joint Health and Wellbeing Strategy.

4. Financial Implications

No financial or resource implications of this paper. Please note, the annual accounts (2016/17) are included in the paper.

5. Sign off

Richard Parry, NKCCG Accountable Officer on 24/05/17

6. Next Steps

The NKCCG Annual Report and Accounts 2016/17 will be formally launched at the North Kirklees Annual General Meeting (and Governing Body) on 9/08/17.

7. Recommendations

- As a statutory duty of the Board, consider the NKCCG Annual Report and Accounts 2016/17
- Discuss and comment on the extent to which the CCG has contributed to the delivery of the Joint Health and Wellbeing Strategy
- Endorse and support the report and accounts prior to formal launch at the AGM

8. Contact Officer

Zoe Thurman, Planning and Development Senior Officer, NHS North Kirklees CCG
01924 504979, zoe.thurman@northkirkleesccg.nhs.uk

Rebecca Spavin, Senior Planning and Development Manager, NHS North Kirklees CCG,
Rebecca.Spavin@northkirkleesccg.nhs.uk

NHS
North Kirklees
Clinical Commissioning Group

Annual report and accounts 2016/17

For longer, healthier, happier lives

Contents

PERFORMANCE REPORT

Performance Overview

The purpose of this overview is to give summary information about the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

Accountable officer's statement

Chris Dowse left a great legacy when she retired at the end of March 2016, having navigated the CCG through a number of changes and prepared the groundwork for future challenges. Nevertheless, this has been a particularly demanding twelve months for the CCG, as indeed it has been for many other organisations working within the health and social care system.

While we received an increase in our budget this year we also saw a growth in demand for health services, especially from those with very complex needs. This contributed to a significant financial challenge which meant we had to look for efficiency savings and work more closely with partners in order to ensure that our population could continue to access the services they need and expect.

As part of our continuing dialogue we launched *Talk health Kirklees* - an open and honest conversation with local people about the things we could do to get better value from NHS spending. I was encouraged by the public feedback and support we received. The majority of those who responded agreed with our proposals but the consultation also allowed us to reflect on the concerns raised and look at ways in which we might support those affected.

In November, the publication of the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) underlined the need for health and social care organisations to work together in order to make sure services are fit for the future.

As we continue to move towards a more integrated approach to health and social care commissioning, a particular highlight for me was the award of a single contract for services for children and young people. Amongst other things, the healthy child programme aims to join-up services across Kirklees, provide better care and support, and deliver financial savings by working in different ways.

During the year, our member practices agreed to support the CCG in its bid to take responsibility for commissioning primary care (GP) services. This was a very positive move and will give us more control over the way GP services are organised and developed to meet local patient need.

Unfortunately, our financial challenge has not gone away and over the coming year we will have to make further difficult and possibly unpopular decisions. However, the organisation has delivered significantly more savings than it has ever done before. I know that this has been really demanding and I am appreciative of the work that has taken place to achieve this.

At a personal level, this year has not been without frustrations. Having two roles (I work for both Kirklees Council and the CCG) has brought a number of benefits, but has also meant that I have not been able to spend time getting to know individuals, the organisation, our member practices and our local communities. I am clear however that all of us, by working together with our member practices, partner organisations and local communities, will deliver our commitment to the vision of 'longer, healthier, happier lives' for North Kirklees residents.

Richard Parry
Accountable Officer

[Page left intentionally blank]

About us

NHS North Kirklees CCG was established and fully authorised as a statutory body on 1 April 2013 and became responsible for the planning and purchasing (commissioning) of local healthcare services on behalf of patients registered in the North Kirklees area. This is our fourth Annual Report and Accounts following the accounts direction within the NHS Act 2006 (as amended). The CCG commissions a range of services including:

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

It serves a population of around 190,000 people across Dewsbury, Batley, Mirfield, Heckmondwike, Cleckheaton, Birstall, Liversedge and Ravensthorpe and has a total annual budget in the region of £248 million. We are a membership organisation comprising 29 GP practices and the CCG is clinically-led, which means that health professionals are actively involved in the development of strategies as well as in day-to-day decision making.

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

Overall, health and wellbeing in Kirklees has improved over recent years, but not for all groups. For example, men and women in Dewsbury have a life expectancy of 5 and 3.6 years respectively shorter than those in nearby Holme Valley. The growing population, especially the sharp rise predicted in the

number of older people; the difficult economic climate and the local picture of ill health and inequality ensures that we are operating in a challenging environment.

Vision and values

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

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

Priorities

Our plans for the future must reflect the needs and aspirations of local people and address identified health inequalities. It's also important that our population has access to the most up to date technologies and that healthcare is delivered in line with the latest guidance. Working with local people, partners and stakeholders, we have identified a range of transformational health priorities which are outlined below. These are described in more detail in our operational and strategic plans which are published on our website.

Care closer to home

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

Transforming general practice

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

Improving hospital services

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

Urgent and emergency care

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

[Page left intentionally blank]

Performance analysis

The year in focus

Together with neighbouring NHS Greater Huddersfield CCG and Kirklees Council we worked to improve access to children's mental health services. This included agreeing additional funding for autistic spectrum condition assessments, launching a one-stop-shop phone service for children and young people with emotional and mental health needs, developing a regional eating disorder service and piloting a scheme to provide support to school pupils with autism and mental health needs.

Working in partnerships, we also developed an innovative healthy child programme, which joins up a range of health and social care support for children and young people aged up to 18 years with existing or emerging mental health problems. The contract for delivery of this new programme was awarded during the year and started on 1 April 2017.

In May, along with a range of partners across Kirklees, Calderdale and Wakefield, we won a national Antibiotic Guardian Award for our efforts to raise awareness of the dangers of the overuse of antibiotics.

In September, further changes to hospital services were implemented as part of a three year improvement programme. This included the opening of new midwife-led birth centres at Dewsbury and Pinderfields Hospitals; the setting up of a dedicated acute gynaecology and early pregnancy assessment service at Pinderfields Hospital; and the centralisation of neo-natal, paediatric inpatient services and acute surgery at Pinderfields Hospital. More changes, including improvements to urgent care services, are scheduled for 2017.

Following input from patients and their carers a new musculoskeletal service started on 1 October. The service is designed to support adults with over 200 different conditions affecting joints, bones, muscles and soft tissues and covers individual services such as orthopaedics, rheumatology and physiotherapy.

Over the year and working with NHS Greater Huddersfield CCG and Kirklees Council, we provided grants to a number of health and social care projects including an arts programme for people with dementia and memory loss in care homes, sheltered housing and community settings; and a scheme delivering community-based activities promoting healthy behaviour called 'Kirklees Eats Well'.

The Kirklees Carers Charter officially launched at an event held in Huddersfield Town Hall in November. The charter aims to encourage organisations in Kirklees to adopt carer friendly practices. The idea originated from a presentation given at one of our Governing Body meetings and has been created in partnership with local carers, Kirklees Council and NHS Greater Huddersfield CCG.

Working together with a range of health and social care provider and commissioning organisations across Harrogate and West Yorkshire, we have developed a draft Sustainability and Transformation Plan (STP) which was published in November. The plan highlights the local and regional challenges we face and the work which must be undertaken collaboratively over the next five years to meet the needs of the 2.5 million people who live here. We are now putting in place a range of governance and supporting structures to allow for the further development and implementation of the plan.

Operating and financial review

In common with the NHS nationally, 2016/17 has been a challenging year financially for the CCG. We delivered more efficiency savings than in any previous year, however, we have also seen significant in-year cost pressures relating to increased elective activity to help reduce waiting list times and an increase in non-elective admissions. This means that we have not been able to achieve all of our financial targets as explained below.

2016/17 Performance

We received two separate allocations of money from the Department of Health for 2016/17 as follows:

- Programme allocation of £243.9 million, which we used to commission health care services for the population of North Kirklees, many of which you can read about elsewhere in this document
- Running costs allocation of £4.1 million which we used to pay for staffing and to provide the support needed to commission local services.

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

As set out in the 2016/17 NHS planning guidance, CCGs were required to hold a 1 percent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in *Five Year Forward View* transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs' 1% non-recurrent monies to be spent. Therefore, to comply with this requirement, NHS North Kirklees CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £2.4m. This additional surplus has been offset against other cost pressures from the current financial year.

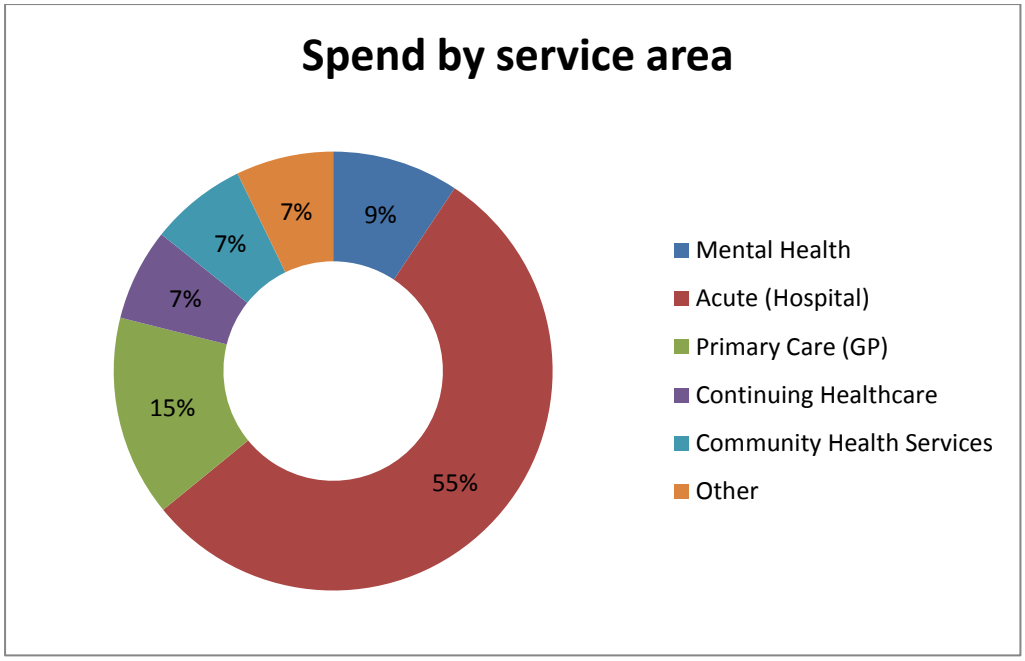
This report summarises how we have invested our budget to deliver and improve healthcare and services for North Kirklees residents. It also highlights some of the key challenges we have addressed during the year and those that face us in the coming years, including efforts to improve the efficiency of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

Programme allocation

We delivered a deficit of £2.8 million rather than a planned surplus of £3.7 million against our programme allocation. Within this position there are two large, exceptional items totalling £3.7 million. These are one off costs in 2016/7 and relate to issues not wholly within the control of the CCG. Without these costs, we would have delivered a surplus of £0.9 million.

By proactively managing our quality, innovation, productivity and prevention (QIPP) programme we delivered £10.9 million of our planned efficiency programme of £13.2 million. Although we did not realise all of our plans, this sum is more than we have ever achieved in a single year and almost £3 million more than last year. In addition, the effort made in 2016/17 put us in a strong position to continue to improve efficiency going forward.

We spend our allocation with a range of organisations. These include NHS and non-NHS hospitals, community organisations, GPs (including prescription costs), and a range of providers of continuing healthcare. The chart below summarises how we spent this money in 2016/17.



Running costs allocation

The CCG is provided with a running costs allocation which allows us to employ staff and pay for commissioning support services. While this year's allocation saw a £0.2 million reduction on the previous year, we were able deliver within budget. This was a challenge which we met by working jointly with other CCGs, the local authority and our provider of commissioning support services. We also focused on those things which help us to make the biggest improvements to the health services available to the people of North Kirklees. Information on levels of staff sickness absence is reported in the financial statements.

Looking forward

Along with the rest of the public sector, we face an increasingly challenging financial position. We received an increase of just over 1.2% per capita in our programme allocation for 2017/18 and are required to provide more services for patients to meet demographic changes within this constrained financial resource. The level of growth is once again lower than in previous years and this represents a significant challenge.

We have worked hard in-year to develop plans to deliver financial and service sustainability. We are planning to reduce our deficit in 2017/18, to return to financial balance by 2018/19, and then to deliver a surplus from 2019/20 onwards. However, this will be difficult and requires the delivery £15 million worth of efficiency savings in the coming year. This means that we are increasing our efforts to reduce

inefficiencies in how services are delivered and ensure we invest our resources in services and treatments that deliver the most benefit for our population.

We have already made some tough decisions about what services we will commission in the future, and in the coming year we will need to make further changes. We take our responsibility to engage with local people seriously and have robust processes in place to ensure that we involve North Kirklees residents fully and appropriately in conversations about service provision and our financial plans. More information about how we involve patients and the public can be found on page 19.

We continue to work with partner organisations, in particular the local authority and NHS Greater Huddersfield CCG, to identify more effective ways of delivering health and social care across the whole of Kirklees and develop and deliver our linked strategies to improve health and wellbeing and economic development and sustainability. We also work closely with NHS Wakefield CCG to manage hospital services, especially in relation to our main provider, the Mid Yorkshire Hospitals NHS Trust.
Primary care commissioning is one of a series of changes set out in the NHS Five Year Forward View which allows CCGs to take on greater responsibility for GP services in their local area. We are taking on delegated responsibility for the commissioning of primary care in 2017/18 and this will enable the CCG to work with member practices to improve the quality of GP services over the coming years.

Better payments practice code

The Better Payments Practice Code requires the CCG to aim to pay all valid invoices by the date due or within 30 days of receipt of a valid invoice, whichever is the later. The NHS aims to pay 95% of invoices within 30 days of receipt, or within agreed contract terms. Details of compliance with the code are given within the notes to the financial statements. We have signed up to the Prompt Payment Code.

Financial probity

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

Annual financial statements

Our annual financial statements are included in this report. These provide more detail on how we have spent our resources in 2016/17.

Sustainable development

We are committed to achieving economic, environmental and social sustainability for our workforce and local communities through our own actions and through our commissioning. Our aims for 2016 to 2018 are to:

- Continue to develop our sustainable development management plan
- Continually improve health and wellbeing and deliver high quality care now and for future generations within available financial, social and environmental resources
- Continue to support staff working through individual teams, staff forum, personal development reviews and staff benefit package.

We will:

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

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

Data and carbon footprint

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

Activities to date

We are working towards achieving the objectives identified above. Since 2014, we have introduced paper shredding bins, changed all printer settings to black and white and double sided, changed the lighting system to LED with manual on/off settings, sent weekly messages to staff reminding them to switch off lights and electronic gadgets when not in use. On a yearly basis, we have worked with our energy supplier to reduce the tariff. We have promoted increased use of working from home, teleconferencing and videoconferencing to reduce travel impact. We have raised awareness of good housekeeping such as closing windows and we now use a hot water boiler rather than kettles. Recently, we introduced a low level energy rated fridge and high efficiency lightbulbs. We recycle all print toners and are currently working with Kirklees Council in respect of recycling paper and plastic. We held a staff Sustainability Awareness Day on 24 March 2016 where we provided information on how individuals could help to reduce waste and be sustainable.

Improve quality

Throughout the year we have worked with a range of partners, patients and the public to develop and improve health services for local people, in line with legal duties under section 14R of the NHS Act 2006 (as amended) and our strategic plan.

Commissioning is about getting the best possible health outcomes for local people by assessing their needs, deciding priorities and strategies, and then buying services on their behalf from providers such as hospitals, clinics and community service providers. Clinical commissioning groups are responsible for the health of their entire population and are measured by how much they improve patient outcomes.

To this end, the CCG uses key indicators to monitor the performance of its commissioning function. A number of these indicators relate to areas where poor performance would have an adverse effect on the quality of services provided to patients and a financial and/or reputational impact on the CCG. We also use national measurements at a local level in order to provide an overview of how we are performing. A year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2017.

Robust performance and risk management reporting systems and processes provide our senior management team and Governing Body with accurate and relevant information relating to performance. This is an ongoing process and CCGs must constantly respond and adapt to changing local circumstances.

Key indicators

Unless otherwise stated, performance data is as at 31st December 2016.

Ambulance handover/turnaround times

The timely handover of care between ambulance and A&E services is essential in order to secure the delivery of high quality patient care. In line with the national target for ambulance handover times, it is expected that all handovers between ambulance and A&E services will take place within 15 minutes and that crews should be ready to accept new calls within a further 15 minutes . The Yorkshire Ambulance Service is currently piloting a new system of coding with a view to improving efficiency, effectiveness and experience. This follows a national review of the impact of the current coding system on ambulance despatch response. Yorkshire Ambulance Service NHS Trust performance shows:

Ambulance handover delays within 15 minutes: 71.8% 

Crew clear delays within 15 minutes: 78.8% 

Cancer waiting times

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

We have worked with partners to ensure the sustained delivery of a maximum waiting time of two weeks from GP referral to first outpatient appointment for all urgent suspected cancer referrals; one month from diagnosis to treatment for all cancers; and two months from urgent referral to treatment for all cancers. The NHS will continue to play a major role in public health, both in terms of delivering specific health programmes such as immunisations or screening, as well as in maximising opportunities to make every patient contact count by providing health improvement advice. The NHS has set targets in relation to improvements in cancer screening coverage. CCG performance shows:

2-week from urgent GP referral to first outpatient appointment: target 93%, actual 94.9% 

One month from diagnosis to treatment: target 96%, actual 100% 

Two months from urgent referral to treatment: target 85%, actual 76.5% 

CCG performance against the national screening programmes standards as at 31 July 2016 shows:

Breast screening: target 80%, actual 67.4% 

Cervical screening: target 80%, actual 71.7%

Bowel screening: target 60%, actual 52.1%

Reduction in avoidable emergency admissions

Reducing avoidable emergency admissions improves the quality of life for people with long-term and acute conditions and their families, as well as reducing pressure on local hospital resources.

A low rate is an indication of a reduction in admissions that are avoidable or preventable and is viewed nationally as a measure of success. The CCG's performance achievement as at 30 November 2016 shows:

Composite measure: target rate 1,670, actual rate 1,783

Healthcare acquired infections

We work with partners to ensure year-on-year reductions in MRSA and Clostridium Difficile infections. The CCG's year to date performance shows:

Number of MRSA: target 0, actual 1

Number of Clostridium Difficile: target 38, actual 38

Referral to treatment

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

18-week referral to treatment – incomplete: target 92%, actual 80.2%.

Patient experience

Each year, NHS England commissions a national GP patient survey to assess experiences. The survey gives patients the opportunity to provide comments and any feedback received is used to inform improvements. The results of the latest survey published July 2016 show:

% of patients who would recommend their GP surgery to someone who has just moved to the local area: target 78.0%, actual 74.2%

% of patients who found it easy getting through to someone at their GP surgery on the phone: target 70.1% , actual 65.7%

% of patients with an overall positive experience of out-of-hours GP services: target 67.4%, actual 65.4%

A&E 4 hour waiting time standards

The NHS standard requires that at least 95% of patients spend 4 hours or less in any type of A&E from arrival, admission, transfer or discharge. The CCG performance achievement for the month of December 2016 shows:

Total time in A&E, four hours or less: target 95%, actual 77.3%

Number waiting over 12 hours: target 0, actual 0

Delayed transfer of care

A delayed transfer of care is where a patient is ready and safe to leave hospital care but is unable to do so and therefore remains occupying a hospital bed. Keeping patients in hospital longer than clinically necessary can have a number of detrimental effects. Long stays can affect morale and mobility and increase patients' risk of hospital-acquired infections. It is hoped that better integration of health and social care will mean fewer delayed transfers of care. The national standard for 2016/17 is to reduce the delayed days rate to 2.5%. Performance data shows:

Delayed transfer of care: delay days rate: target 2.5%, actual 2.3%

Dementia

A key component of the Dementia Challenge, launched in 2012, is to improve diagnosis rates for dementia so that more patients can receive the appropriate care and support. NHS England's ambition is to increase the dementia diagnosis rate to 67%. The CCG's performance achievement against this standard shows:

Dementia Diagnostic Rate: target 67%, actual 68.3%

Mental Health

In October 2014, NHS England and the Department of Health set out an ambition to introduce access and waiting time standards across all mental health services between 2016 and 2020. These commitments were reaffirmed in the NHS Mandate. Standards focus on three areas where timely access to evidence-based care is of particular importance in improving longer term mental health, physical health and

recovery-focused outcomes, and in reducing the distress experienced by individuals and their families. The CCG's performance achievement against these standards shows:

50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral: actual 67%	
75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral: actual 98.8%	
95% of people referred to the Improved Access to Psychological Therapies programme will be treated within 18 weeks of referral: actual 98.5%	

Patient and public involvement

We have a strong commitment to involving the public and patients. In line with the duties identified in Section 14Z2 of the NHS Act 2006 (as amended) we seek the views of patients, carers and the public through a range of mechanisms summarised below:

Your health, your say network

We maintain a database of local people who want to get involved in the development of new and existing services and share their experiences. This can range from being part of a discussion session, completing a questionnaire or joining a service user group.

Local patient reference groups

GP patient reference groups are designed to give patients the opportunity to contribute to the continuing improvement of their practice. Every group is unique and focuses on meeting local needs.

Patient reference group network

The network has been set up by NHS North Kirklees CCG as a forum to gather together representatives from each GP practice patient reference group. The network meets quarterly to learn more about our plans, consider and discuss proposals and engage with us on decision making.

Quarterly public events

The CCG's quarterly events are open to members of the public and representatives of voluntary and community sector organisations. They provide an opportunity to find out more about what the CCG does, participate in discussions and ask questions.

Voluntary and community sector

The CCG has an ongoing relationship-building programme with community and voluntary sector organisations. This year we held sessions for those with an interest in a range of commissioning priority areas.

NHS challenge

NHS Challenge is a fun but thought provoking board game which enables us to seek views about local commissioning priorities. The game format allows us to involve a wider and more diverse range of people than more traditional involvement methods.

Patient Stories

Patient stories have continued to be a part of our Governing Body meetings. During 2016/17 patients shared their experiences of the cardiac rehabilitation unit, a GP patient participation group, and WellChild nurses.

Engagement

We regularly seek the views of our public and patients to learn more about their experiences of local health services and inform commissioning decisions. During October we launched *Talk health Kirklees*, an open and honest conversation about our financial challenge and how we might achieve efficiency savings. Over the year we also asked people for their views on children's mental health services and worked with a range of partners to support conversations about services for adults with learning difficulties and other special needs. Along with our West Yorkshire and Harrogate STP partners we commissioned Healthwatch to gather public views on stroke services. All our engagement reports are published on the CCG website.

Awareness campaigns

We use local media, our website and social media channels to keep our population informed. In July we launched a campaign to encourage people to think about using NHS resources more effectively and to purchase small quantities of over-the counter-medicines for short term use rather than requesting them on prescription. In September we ran a high profile campaign designed to encourage local patients to go online to make GP appointments, order medicines and check their medical records. We also supported a range of national campaigns including *Stay Well this Winter* and promotions designed to encourage take up of cervical screening, the correct use of antibiotics, support healthy eating, and raise awareness of the symptoms of cancer.

Reducing health inequality

The CCG has complied with its duty under Section 14T of the NHS Act 2006 (as amended) relating to the reduction of inequalities through membership of the Health and Wellbeing Board and active engagement in the development of the Joint Health and Wellbeing Strategy. More information can be found in the *Equality disclosures* section of this report on page 57.

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

Health and wellbeing strategy

The CCG is a member of the Kirklees Health and Wellbeing Board and through this has contributed to the development of the Joint Health and Wellbeing Strategy and the Kirklees Health and Wellbeing Plan. The work of the Board and delivery of the strategy and plan is reflected throughout this document. Key areas of work and discussion have included the integration of health and social care services; healthy child programme and related procurement; care home strategy; Transforming Care Partnership; Kirklees Joint Strategic Assessment; and Child and Adolescent Mental Health Services (CAMHS) transformation plan.

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

Richard Parry
Accountable Officer
24 May 2017

ACCOUNTABILITY REPORT

Members' report

Member practices and profiles

Member practices forming the membership body of the CCG are listed in the table below.

PRACTICE NAME	PRACTICE MANAGER	GP LEAD
Albion House	Anne Wade	Adnan Jabbar
Dr Mahmood & Partners	Mohammed Zahoor	Yasar Mahmood
Sidings Health Centre	Gillian Lawson	Yunus Asmal
Wellington House	Roy Partington	Stuart Lawson
Savile Town Medical Centre	Taveed Jan	Haffizullah Bhat
North Road Suite	Elaine Oldroyd, Lynne Bolton	Natarajan Chandra
Greenside Surgery	Emma Marshall	Victor D'Ambrogio
Blackburn Road Medical Centre	Jan Randall	David Fowers
Healds Road Surgery	Robina Naz	Nasar Khan
Broughton House Surgery	Jean Siedlecka	Jill Gogna
Batley Health Centre	Janey Hellings	Syed Hassan
Eightlands Surgery	Lauren Hill	Muhammad Dadibhai
Kirkgate Surgery		Shanza Bila
Liversedge Health Centre	Robina Naz	Nasar Khan
Mirfield Health Centre	Joanne Swords	Mohammed Hussain
Undercliffe Surgery	Andrea MacKay	Antony Goodwin Joanne Hartwell Mohammed Hussain
Grove House Surgery	Dawn Beadle	Brian Lynch
Calder View Surgery	Clare Townend	Heather Spencer
Windsor Medical Centre	Sylvia Brown	Mangipudi Jayashree
St John's House	Emma Marshall	Sarah Nicholls
Thornhill Lees Medical Centre	Mohammed Yaqoob	Yakub Patel
Mount Pleasant Medical Centre	Lynn Batley	Yaqub Hussain

PRACTICE NAME	PRACTICE MANAGER	GP LEAD
The Paddock Surgery	Karen Frank	Christopher Robinson
The Greenway Medical Practice	Angie Dickinson	Belinda Scrivings
Cherry Tree Surgery	Margaret Brook	Rajinder Sood
Parkview Surgery	Carol Eastwood	Yasar Mahmood
Albion Mount Medical Practice	Karen Goodfellow	Hanume Thimmegowda
Brookroyd Surgery	Julie Jones	Nigel Myers
Victoria Medical Practice	Louise Gregory	Jeremy Sager

[Page left intentionally blank]

Composition of governing body and register of interests

NAME	POSITION	INTEREST
Richard Parry	Interim Accountable Officer (from March 2016)	• Director of Commissioning, Adult Health and Social Care, Kirklees Council
David Kelly	Chair	• Partner, Brookroyd Surgery • GP Director, Heckmondwike Health Centre Pharmacy • Practice is member of and has a share in Curo Health Limited • Wife is a shareholder in Floor Target and a nurse at Bradford Royal Infirmary
Pat Keane	Interim Chief Operating Officer (from February 2016)	• Employed by NHS Wakefield CCG • Member of NHS Wakefield CCG Governing Body
Steve Brennan	Chief Finance Officer	• Member of the NICE Highly Specialised Technologies Committee (April – September 2016) • Trustee Overgate Hospice (From December 2016)
Deborah Turner	Head of Quality and Safety and Chief Nurse (on secondment between April-October 2016)	• Specialist advisor to the Care Quality Commission. • Associate Director of Nursing, Calderdale and Huddersfield NHS Foundation Trust (2 days a month)
Penny Woodhead	Head of Quality and Safety and Chief Nurse (between April-October 2016)	• Head of Quality, joint role with NHS Calderdale and NHS Greater Huddersfield CCGs and member of both Governing Bodies • Director of Bailey Brothers Builders Ltd • Registered Nurse on Nursing and Midwifery Register
Rachael Kilburn	Governing Body Member	• Partner, Parkview Surgery and Dr Mahmood & Partners • Practices are members of and have a share in Curo Health Limited
Andrew Cameron	Governing Body Member	• Partner, Greenway Medical Practice • Practice is member of and has a share in Curo Health Limited • Practice is sole provider of medical services to Hollybank Trust residential home • Wife is partner at Grange Group Practice in Huddersfield, which is a member of Huddersfield Prime Health Federation.
Yasar Mahmood	Governing Body Member	• Partner, Parkview Surgery and Dr Mahmood & Partners • Practices are members of and have a share in Curo Health Limited
Kathryn Greaves	Governing Body Member (until 30 June 2016)	• Practice is member of and has a share in Curo Health Limited • Occasional practice tutor, Leeds Metropolitan and Leeds universities • Husband employed by The Charity Service, which is responsible for administering third sector grants on behalf of several CCGs
Sarah Sowden	Governing Body Member (from July 2016)	• Trainee Advanced Nurse Practitioner at Park View Surgery • Practice is member of and has a share in Curo Health Limited

NAME	POSITION	INTEREST
Khaled Naeem	Governing Body Member	• Partner, Mount Pleasant Medical Centre • Practice is member of and has a share in Curo Health Limited • Director, Mount Pleasant Pharmacy, Dewsbury • Personal injury claims medical legal expert • Parent Governor, Heckmondwike Grammar School • Wife employed by Batley Girls High School Visual Arts College
Nadeem Ghafoor	Governing Body Member	• GP, Liversedge Health Centre, Healds Road Surgery • Practice is member of and has a share in Curo Health Limited
Adnan Jabbar	Governing Body Member	• Partner, Albion Street Surgery • Partner, Cherry Tree Surgery • Practice is member of and has a share in Curo Health Limited
Kiran Bali	Lay Member (until May 2016)	• No interests to declare
Fatima Khan-Shah	Lay Member (from June 2016)	• Director, Investor in Carers • Director, Investor in Carers Consultancy Ltd • Director, MS Health Ltd • Scrutiny Co-optee Kirklees Council • Governor Reinwood Nursery Infant School
Joanne Crewe	Nurse Representative (until September 2016)	• Operational Director, Harrogate and District NHS Foundation Trust
Richard Jenkins	Secondary Care Consultant (from August 2016)	• Medical Director and Deputy CEO at Barnsley Health NHS Foundation Trust • BMA Member • Fellow Royal College of Physicians • Member of the Labour Party • Member of Diabetes UK
Julie Elliott	Lay Member	• Director, Julie Elliott Ltd • Lecturer, Huddersfield University
Colin Meredith	Lay Member	• Director, Utley General Services Ltd • Employee, Rastrick High School Academy Trust
IN ATTENDANCE		
Rachel Spencer-Henshall	Director of Public Health, Kirklees Council	• No interests to declare

Audit committee

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

NAME	POSITION
Colin Meredith	Lay Member, Chair
Julie Elliott	Lay Member, Vice Chair
Andrew Cameron	Governing Body Member (until March 2016)
Adnan Jabber	Governing Body Member (from March 2016)
Rachael Kilburn	Governing Body Member (on secondment from April 2016)
IN ATTENDANCE	
Steve Brennan	Chief Finance Officer
Helen Kemp Taylor	Acting Head of Internal Audit (from October 2015)
Leanne Sobratee	Internal Audit Manager, West Yorkshire Audit Consortium
Tim Cutler	External Audit Representative, KPMG
James Boyle	External Audit Representative, KPMG (from December 2016)
Thilina De Zoysa	External Audit Representative, KPMG (from November 2016)
Pat Patrice	Governance, Corporate Affairs and Senior Manager
Steve Nicholls	Local Counter-Fraud Specialist

Personal data related incidents

There were no incidents requiring a report to or an investigation by external bodies such as the Information Governance Commissioner or the Health and Safety Executive. We have had no serious untoward incidents relating to data security breaches.

Statement as to disclosure to auditors

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

- So far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report
- The member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

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

Statement of accountable officer's responsibilities

The National Health Service Act 2006 (as amended) states that each clinical commissioning group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Richard Parry to be the Accountable Officer of NHS North Kirklees CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the clinical commissioning group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable
- Keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the clinical commissioning group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- For safeguarding the clinical commissioning group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended) and with a view to securing

continuous improvement in the quality of services (in accordance with Section 14R of the National Health Service Act 2006 (as amended))

- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each clinical commissioning group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the clinical commissioning group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Group Accounting Manual issued by the Department of Health and in particular to:

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

To the best of my knowledge and belief, and subject to the disclosures set out below, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my clinical commissioning group Accountable Officer Appointment Letter. I also confirm that:

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

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

Disclosures:

- The CCG overspent by £2.8m in 2016/17

Governance statement

Introduction and context

NHS North Kirklees CCG is a body corporate established by NHS England on 1 April 2013 under the NHS Act 2006 (as amended).

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

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the NHS Act 2006 (as amended).

Scope of responsibility

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

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

This year, I have focused on the issue of integration by working closely with neighbouring CCGs and Kirklees Council. I am responsible for North Kirklees CCG becoming a member of the joint committee, Healthy Futures, which is made up of the 11 CCGs across West Yorkshire and will come into effect from April 2017.

Governance arrangements and effectiveness

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

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

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

The governing body and committee structure

The constitution sets out the duties, responsibilities and overall framework for the good governance of the CCG. The constitution, approved by NHS England in March 2017, sets out the structures, systems and process for the discharging of duties, delivery of responsibilities and arrangements for decision-making.

The Governing Body comprises a clinical leader who is the Chair, five GP representatives of member practices, a chief nurse, a practice nurse, chief finance officer, a secondary care consultant member, three lay members with specific responsibility around governance, audit, risk, quality, finance, performance and patient and public involvement.

As Accountable Officer, I am also a member of the Governing Body. All Governing Body members have important roles within the governance framework of the CCG. The Governing Body has an ongoing role in reviewing the CCG's governance arrangements to ensure that these continue to reflect the principles of good governance. The Audit Committee plays a role in supporting this by providing assurance to the Governing Body around the risk and governance processes within the CCG.

During the year 2016/17, the CCG's Governing Body met on seven occasions. All meetings were held in public and agendas were structured to deal with strategic, performance, quality assurance, risk and governance issues. The Governing Body has established three principal committees for the conduct of its business. Each committee is chaired by a member of the Governing Body and all have important roles in the governance framework.

Audit committee

The Audit Committee has delegated responsibility from the Governing Body for oversight of integrated governance, risk management and internal control, internal audit, external audit, reviewing the findings of other significant assurance functions, counter fraud and financial reporting.

The committee is authorised to seek any information it requires from any employee. All employees are directed to cooperate with any such request made by the committee. The Audit Committee met on seven occasions over the period of this report and highlights are as follows. The committee:

- Approved the auditor appointment and the NHS Protect counter fraud self-review tool
- Approved, reviewed and recommended to Governing Body the following: the Governing Body Assurance Framework; emergency planning; information governance including senior information responsible officer (SIRO) reports, risk reports, gifts, hospitality and sponsorship, register of interests, standards of business conduct and sponsorship; use of the CCG seal; risk management framework; health, safety and security; audit annual report; CCG constitution; equality and diversity objectives; risk register; and terms of reference
- Approved, reviewed and recommended to Governing Body the following: financial elements of the annual report; head of internal audit opinion; any issues occurring regarding compliance with standing orders; risk based approach to contract management and business case approval log; chief finance officers position statement; annual accounts and financial statements; losses and compensation reports; prime financial policies and tender waiver logs
- Approved, reviewed and recommended to Governing Body the following for external audit: external reports on counter fraud; external audit plans and fees; and external audit reports including technical updates and progress reports
- Approved, reviewed and recommended to Governing Body the following for internal audit: internal audit progress reports
- Has undertaken an annual review of its performance.

Terms and remuneration committee

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

The committee approved, reviewed and recommended to Governing Body the following: pay review for Agenda for Change; total reward package; contractual status of Governing Body members; remuneration terms and conditions for all posts not subject to Agenda for Change; the process for Governing Body member succession planning; the recruitment and retention premium; the recruitment timeline for Governing Body members whose tenures were due to expire; the terms of reference, the work plan and Terms and Remuneration Committee annual report. Refer to page 49 for membership and other details.

Quality, performance and finance committee

The Quality, Performance and Finance Committee has delegated responsibility from the Governing Body for securing continuous improvement in the quality of services commissioned and ensuring patient experience, clinical effectiveness and patient safety (including safeguarding) is stratified to support commissioning decisions. The committee met on 12 occasions and highlights are as follows. The committee:

- Identified and reported appropriate risks relating to quality, clinical effectiveness, patient safety, safeguarding and patient experience as described in the terms of reference
- Received and reviewed reports and subsequent action plans from providers in relation to internal and external scrutiny including the Care Quality Commission and National Patient Safety Agency
- Oversaw delivery of the CCG's quality, financial and commissioning strategies including approval of business cases within the scheme of delegation
- Agreed key performance indicators regarding achievement of financial targets and ensured effective monitoring
- Received, reviewed and recommended the following to Governing Body for implementation: the terms of reference; the work plan and annual report; the quality and safety reports; the quality and safety strategy; the nursing strategy; finance and contracting reports; performance reports, escalating concerns where appropriate; quarterly safeguarding reports; long, medium term and

annual financial plans including monthly QIPP reports; personal health budgets for continuing health care and updates in relation to Mid Yorkshire Hospitals NHS Trust; business case logs, joint transformation and co-commissioning updates; annual planning requirements; walk-in centre attendance provision and primary care improvement scheme

- Approved funding for NICE technical appraisals.

UK corporate governance code

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

The CCG has continued to reflect on its governance arrangements following a review by the law firm Capsticks in February 2015. We have implemented bi-monthly Governing Body meetings and progress has been made on updating the front sheet template for committees to make it more robust, understandable and clear. Agenda setting meetings take place throughout the year and there are clear plans for the production of minutes, action logs and agendas. The introduction of new guidance by NHS England has supported the management of the CCG's conflicts of interests and helped assure Governing Body members that appropriate processes are in place. More recently, we introduced Joint Senior Management Team and Clinical Strategy Group meetings with NHS Greater Huddersfield CCG as part of a move towards greater integration and streamlined decision making

Discharge of statutory functions

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

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

Responsibility for each duty and power has been clearly allocated to a head of service. Heads of service have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Risk management arrangements and effectiveness

The Integrated Risk Management Framework was updated and revised during the year to ensure it accurately describes the CCG's approach to managing its risks. The revised framework was reviewed by the Audit Committee in March 2016, followed by approval at Governing Body in April 2016.

NHS North Kirklees CCG is committed to the active management of risk within the services it commissions. It has done this during 2016/17 by continuing to develop and maintain a positive risk management culture throughout the organisation. It has sought to minimise risks wherever possible both internally and to service users, the public, staff, members and other stakeholders as far as reasonably practicable, and in accordance with current guidance, legislation and best practice.
Specifically, the CCG's Integrated Risk Management Framework describes:

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

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

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

When untoward events occur, the incident reporting system is configured to direct a notification to the reporter's line manager who has a responsibility to investigate and sign off the incident and identify any learning opportunities. The incidents reported during the year range from staff accidents to information governance and telecommunication issues.

Identification of risk

The CCG has identified risks during the year as described in the Integrated Risk Management Framework. Triangulation of soft and hard information from different sources gives assurance that all significant risks have been captured. The key sources of information used to check completeness of risk capture are:

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

Capacity to handle risk

Within the risk management arrangements and effectiveness section of this document I have set out the ways in which leadership is given to the risk management process within the CCG.

All risk owners, senior reviewers and heads of service, are trained and equipped to manage risk in a way that is appropriate to their authority and duties. The CCG's Integrated Risk Management Framework clearly sets out the duties and responsibilities of risk owners and senior reviewers.

We are supported in the management of risk by a Governance Manager who provides expert advice on the use of the risk management system, identifies good practice and provides guidance to staff on the identification of risks and associated controls and assurances. Regular meetings with risk register owners from neighbouring CCGs allows advice and learning to be shared.

During 2016/17, all risk owners and senior reviewers have received additional support to review their risks with the Governance Manager to ensure they are correctly identified, accurately reported, scored and managed.

Risk assessment

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

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

Evaluation of risk

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

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

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

Risk prioritisation

Each risk was given a risk score which determined the prioritisation and allocation of resource. Higher scores have a higher priority for action as the impact of failing to reduce the risk is greater.

Each risk had an agreed target score to indicate the level at which the risk is acceptable to the CCG. The target score was reviewed as part of each review cycle and four risk review cycles took place during 2016/17.

Risk management

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

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

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

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

The final risk register considered in 2016/17 included the following highest scoring risks:

PRINCIPLE RISK	KEY CONTROLS
Risk that Mid Yorkshire Hospitals NHS Trust will not achieve 18 weeks referral to treatment target, affecting the CCG's quality premium payment.	A recovery plan has been agreed with NHS Improvement. CCG has oversight of delivery.
Risk of failing to deliver QIPP requirement.	Plan and monthly monitoring in place. Appointment of director lead and additional staff capacity in place.
Risk of orthopaedic referrals exceeding annual contract value.	Ongoing monitoring of numbers of referral. Education and support for referring clinician
Risk CCG may have to fund acute trust legacy and transition costs from allocation.	Arbitration process in place.
Risk of delay in development of integrated emergency department model.	Task and finish group established.
Risk that out-of-hours primary care provider will fail to meet key targets and standards.	Service performance monitoring and reporting process in place.
Risk that the system resilience for unplanned care will not deliver required A&E performance standard due to level of activity /resources.	A&E Improvement Group for the Mid Yorkshire area has been established with responsibility for planning and ongoing monitoring.
Risk that patients may not receive optimum care at Mid Yorkshire Hospitals NHS Trust.	Remedial action plan approved by the Trust Development Authority. Executive Improvement Board established which will focus on 5 key priorities.
Risk of reduced access to neuroscience services.	Regular monitoring meetings and escalation process in place.

Other sources of assurance

Internal control framework

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

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The Integrated Risk Management Framework establishes the risk and control framework for the CCG. The framework links supporting and associated policies and comprises five elements:

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

Annual audit of conflicts of interest management

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

The CCG's Conflict of Interest policy was approved by Governing Body in March 2017. In May 2017 internal audit carried out a review of the CCG's conflicts of interest management which confirmed that our arrangements were mostly in line with the statutory guidance issued by NHS England in June 2016 and recommended that:

1. The CCG should take additional measures to publicise the Conflict of Interest Guardian role.
2. It should consider whether the gifts and hospitality register is expanded to capture the full minimum in the guidance.
3. The process for managing breaches in the conflict of interest statutory guidance should be included in the Conflict of Interest policy and the process for ensuring that anonymised details of breaches are published on the CCG website and promptly reported to NHS England.

These recommendations will be fully actioned by the end of July 2017.

Data quality

The quality of data presented to the committees and the Governing Body continues to evolve. The committee checklist is completed after every Governing Body or committee meeting as part of the annual assessment process, and the information provided from this shows that the majority of Governing Body members confirm that they receive 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 that a good quality of data is provided across a range of areas within finance, contracting, performance, quality and patient experience. The CCG's governance team continues to review the production of papers, completion of front sheet and meeting deadlines.

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. The CCG has a Senior Information Risk Owner (SIRO), Caldicott Guardian and information governance (IG) lead together with a number of information asset owners who are responsible for information risk management within the area of the organisation they manage.

The organisational approach to information governance compliance is set out in the organisation's information governance management framework and annual information governance improvement plan, which also includes a programme of work relating to information asset risk management. The

information governance management framework and annual improvement plan provide a means to monitor compliance and continual improvement. Over the year we have been working with our information asset owners to continue to embed effective information risk management arrangements. This has included making sure that transfers of paper and electronic personal information are secure.

The information governance management framework is supported by the annual information governance toolkit self-assessment submission. The information governance toolkit is a continual improvement tool published and managed by NHS Digital. It draws together the legal rules and guidance and presents them as a set of information governance requirements (or standards).

We place high importance on ensuring there are robust information governance systems and processes in place and we have developed processes and procedures in line with the requirements of the information governance toolkit. During 2016/17 we reviewed our policies and strategies in relation to information governance. The CCG achieved a score of 95 % (overall grade of 'satisfactory') as part of the 2016/17 self-assessment submission.

All staff undertake annual training in information governance including confidentiality, data protection and information security. During the year over 90% of staff received annual update training. We take steps to ensure that staff are reminded throughout the year of both the risks and good practice when working with information, in particular personal and sensitive information. As part of our proactive awareness raising we provide staff with a copy of an information governance handbook which provides guidance and best practice and sets out roles and responsibilities. Processes are in place for incident reporting and investigation of serious incidents relating to information to ensure that we improve our processes to prevent future incidents occurring.

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.

Third party assurances

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

Control issues

During 2016/17 there have been difficulties in respect of performance achievement primarily relating to acute access and waiting times targets/standards. The CCG is actively working with commissioning and provider partners and has established a robust performance management system and process that is demonstrating a positive impact on performance improvement going forward into 2017/18.

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

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

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

- The Quality Performance and Finance Committee receives and scrutinises regular detailed reports on the financial performance of the CCG, including updates on the delivery of our quality, innovation, productivity and prevention plans (QIPP)
- The Audit Committee receives a regular update from the Chief Finance Officer on the financial position of the CCG. It also receives and reviews the work and opinions of our internal and external auditors
- Latest ratings for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework 2016/17 can be found here www.nhs.uk/service-search/scorecard/results/1175. Year end results will be available in July 2017.

Delegation of functions

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

Counter fraud arrangements

The CCG's counter fraud arrangements comply with NHS Protect's standards for commissioners: fraud, bribery and corruption. They are underpinned by the appointment of accredited local counter fraud specialists, the introduction of a CCG-wide countering fraud and corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud.

Audit Committee reviews and approves an annual counter fraud plan, identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud. The counter fraud team also produces an annual report and regular progress reports for the review and consideration of the Chief Finance Officer and Audit Committee.

Counter fraud specialists undertake an annual self-assessment of compliance against NHS Protect's standards, which is reviewed and approved by the Chief Finance Officer prior to submission to NHS Protect.

Head of Internal Audit Opinion on the effectiveness of the system of internal control at NHS North Kirklees Clinical Commissioning Group for the year ended 31 March 2017

Roles and responsibilities

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

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

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

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

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

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

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

- ***Significant assurance*** **can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.**

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 2016/17 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to mature.

The Governing Body has identified its objectives, risks, controls, sources of assurance and gaps in control/assurance and has created and agreed an Assurance Framework. A review of the design and operation of the Assurance Framework and associated processes was completed in 2016/17 and I can conclude that the methodology surrounding the design and operation of the framework has been sound.

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

The 2016/17 Internal Audit Plan was approved by the Audit Committee in May 2016. 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
NO	No 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 completed during 2016/17 to date; the first was a review of the evidence submitted by the CCG in its Information Governance

Toolkit (V13) from March 2016. The review was carried out to highlight additional evidence requirements to support the CCGs self-assessment score for the Information Governance Toolkit submission in March 2017. Further advisory work has been completed to provide a gap analysis in respect of the evidence that the CCG was planning to submit in its Information Governance Toolkit (V14) on 31 March 2017.

The audit plan is designed to cover the 2016/17 financial year. The outcome of the assurance audit reports as at 23 May 2017 are summarised below. The audit in italics will be completed by the 31 May 2017.

Audit	**Assurance Level**
Governance & Risk Review (Including review of Assurance Framework)	Significant
Conflicts of Interest	Significant
Business Continuity Planning	Significant
Personal Health Budgets	Significant
Performance Management	Full
Lead Commissioning and Collaboration	Significant
Quality, Innovation, Productivity and Prevention (QIPP)	Significant
Business Intelligence	Significant
Financial Transactions	Significant
Individual Funding Requests	Significant
Safeguarding	*Report in Draft: Significant*

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

Helen Kemp-Taylor, Managing Director and Head of Internal Audit
Audit Yorkshire
23 May 2017

Review of the effectiveness of governance, risk management and internal control

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

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed. We will continue to work with internal audit to refresh, improve and strengthen the

Governing Body Assurance Framework, and if appropriate a plan to address areas of development and ensure continuous improvement of the system will be put in place.

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

Conclusion

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

Richard Parry
Accountable Officer
24 May 2017

Remuneration and staff report

Remuneration report

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

Terms and remuneration committee report

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

NAME	POSITION
Kiran Bali	Lay member, Chair (until May 2016)
Fatima Shah-Khan	Lay member, Chair (from June 2016)
Colin Meredith	Lay member, Vice Chair
Julie Elliott	Lay member
Khalid Naeem	Governing Body Member

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

Policy on remuneration of senior managers

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

Remuneration of very senior managers

Where one or more senior managers of the CCG is paid over £142,500 per annum, we must explain the steps taken by the CCG to ensure this remuneration in reasonable. The CCG does not have any managers who are paid more than this sum.

Senior managers' performance related pay

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

Payments to past senior managers

The CCG has not made any awards to past senior managers in addition to the remuneration disclosed in this report.

Policy on senior managers' contracts

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

NAME AND TITLE	CONTRACT DATE	UNEXPIRED TERM	NOTICE PERIOD
David Kelly* Chair	01.12.12	Ends 31.10.18	3 months
Richard Parry – Seconded from Kirklees Council Accountable Officer	01.04.16	Ends 30.09.17**	3 months
Pat Keane – Seconded from Wakefield CCG Chief Operating Officer	01.04.16	Ends 31.03.18	3 months
Steven Brennan Chief Finance Officer	01.04.13	No end date	3 months
Deborah Turner Head of Quality and Safety and Chief Nurse	01.04.13	No end date	3 months
Nadeem Ghafoor* Governing Body Member	01.12.12	Ends 31.10.18	3 months
Yasar Mahmood* Governing Body Member	01.12.12	Ends 31.10.18	3 months
Khaled Naeem* Governing Body Member	01.07.13	Ends 30.06.19	3 months
Kathryn Greaves Governing Body Member	01.07.13	Ends 30.06.16	3 months
Sarah Sowden Governing Body Member	01.07.16	Ends 30.06.19	3 months
Rachael Kilburn* Governing Body Member	01.12.12	Ends 31.10.18	3 months
Richard Jenkins Secondary Care Clinician	01.08.16	31.07.19	3 months
Joanne Crewe* Secondary Care Nurse	01.11.12	Ended	3 months
Julie Elliott* Lay Member	30.01.13	Ends 28.01.19	3 months
Kiran Bali Lay Member	29.05.13	Ended 28.05.16	3 months
Fatima Khan-Shah Lay Member	01.06.16	Ends 31.05.19	3 months
Andrew Cameron Governing Body Member	02.10.13	Ends 31.05.17	3 months
Adnan Jabbar Governing Body Member	01.01.14	Ends 31.05.17	3 months
Colin Meredith Lay Member	01.11.15	Ends 31.10.18	3 months

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

*****Individual has had two terms of office and will not be eligible for a further term.**Contract extended for 6 months.

Senior manager remuneration (including salary and pension entitlements)

The table below shows the salaries and allowances for all senior managers who served during the 2016/17 financial year compared to 2015/16.

	2016/17						2015/16					
Name and title	Salary/ Fee bands of £5,000	Expense payments (taxable) rounded to nearest £100	Performance pay and bonuses bands of £5,000	Long term performance pay and bonuses bands of £5,000	All pension related benefits bands of £2,500	TOTAL bands of £5,000	Salary bands of £5,000	Expense payments (taxable) rounded to nearest £100	Performance pay and bonuses bands of £5,000	Long term performance pay and bonuses bands of £5,000	All pension related benefits bands of £2,500	TOTAL bands of £5,000
	£000	£00	£000	£000	£000	£000	£000	£00	£000	£000	£000	£000
David Kelly Chair	115-120				15-17.5	135-140	110-115				12.5-15	125-130
Richard Parry Chief Officer	60-65				10-15	75-80	115-120 (Chris Dowse)				22.5-25	140-145
Pat Keane Chief Operating Officer	45-50					45-50						
Steven Brennan Chief Finance Officer	95-100				12.5-15	110-115	90-95				12.5-15	105-110
Deborah Turner Head of Quality and Safety & Chief Nurse	65-70				7.5-10	75-80	60-65				7.5-10	70-75
Nadeem Ghafoor Governing Body Member	65-70					65-70	65-70					65-70
Yasar Mahmood Governing Body Member	50-55					50-55	50-55					50-55
Khaled Naeem Governing Body Member	30-35					30-35	30-35					30-35
Kathryn Greaves Governing Body Member	0-5					0-5	10-15					10-15
Sarah Sowden Governing Body Member	5-10					5-10						
Rachael Kilburn Governing Body Member	25-30					25-30	25-30					25-30

	2016/17						2015/16					
Richard Jenkins Secondary Care Clinician	20-25					20-25	5-10 (Matt Shepherd)					5-10
Joanne Crewe Nurse Representative	5-10					5-10	5-10					5-10
Tony Gerrard Lay Member							5-10					5.10
Julie Elliott Lay Member	5-10					5-10	10-15					10-15
Kiran Bali Lay Member	0-5					0-5	5-10					5-10
Fatima Khan-Shah Lay Member	5-10					5-10						
Andrew Cameron Governing Body Member	50-55					50-55	50-55					50-55
Adnan Jabbar Governing Body Member	50-55					50-55	50-55					50-55
Colin Meredith Lay Member	5-10					5-10	0-5					0-5

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

Pension benefits as at 31 March 2017

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

Name and title	Real increase in pension at pension age bands of £2,500	Real increase in pension lump sum at pension age bands of £2,500	Total accrued pension at pension age at 31 March 2016 bands of £5,000	Lump sum at pension age related to accrued pension at 31 March 2016 bands of £5,000	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2016	Employers contribution to partnership pension
	£000	£000	£000	£000	£000	£000	£000	£000
David Kelly Chair	0-2.5	2.5-5	10-15	35-40	222	45	267	n/a
Steven Brennan Chief Finance Officer	0-2.5	0-2.5	25-30	80-85	438	35	473	n/a
Deborah Turner Head of Quality and Safety & Chief Nurse	2.5-5	5-7.5	20-25	60-65	304	44	348	n/a

Cash equivalent transfer values

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

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

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

Real increase in CETV

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

Compensation on early retirement or for loss of office

The CCG has not paid any compensation in relation to early retirement or loss of office.

Pay multiples

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

The banded remuneration of the highest paid member of the Governing Body in NHS North Kirklees CCG in the financial year 2016/17 was £125,000 - £130,000 (2015/16, £115,000-£120,000). This was 3.52 (2015/16, 3.65) times the median remuneration of the workforce, which was £36,250 (2015/16, £32,086).

In 2016/17, no employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £5,000 to £130,000.

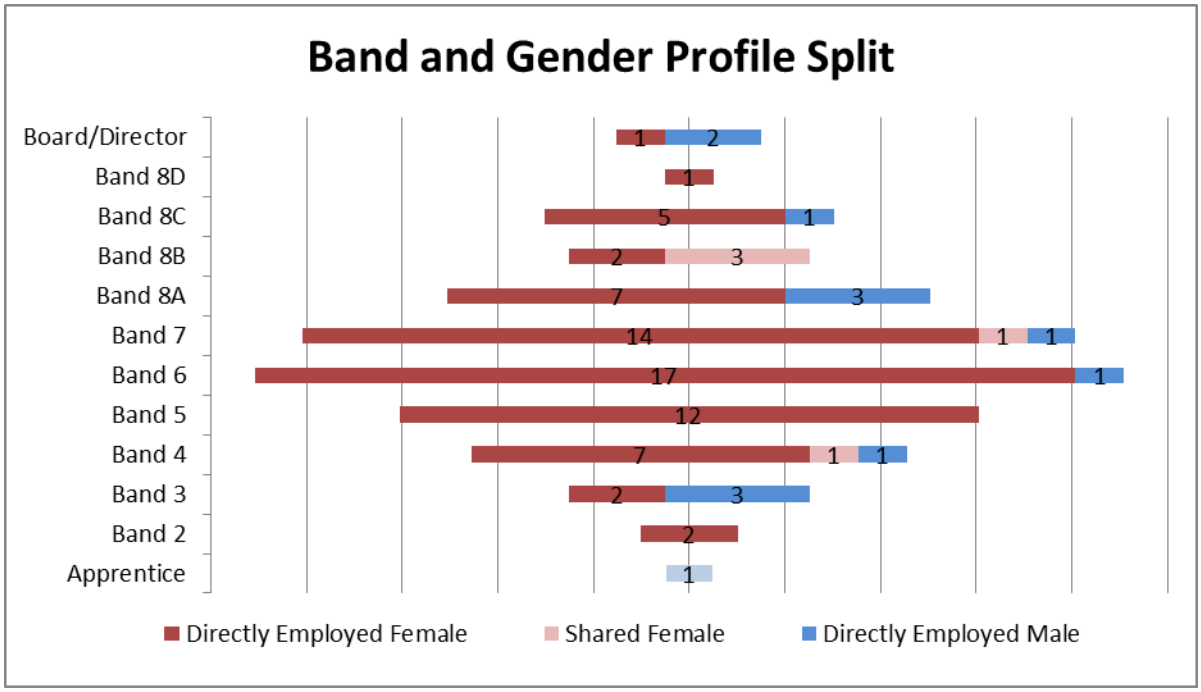
Total remuneration includes salary, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff report

Number and composition of staff

The CCG workforce profile is shown below. Information is based on the directly employed staff as at 31 January 2017. Information relating to Governing Body members is reported separately. Some data is not shared to avoid identification of individuals. Details of staff numbers and costs can be found in the Annual Accounts.

Sex	Headcount	Very senior management (VSM)	All other staff
Female	75		
Male	13		
Total	**88**	**2**	**86**



Sickness absence data

Sickness absence data is reported in the financial statements.

Staff policies

See page 58.

Expenditure on consultancy

The CCG has not had any expenditure on consultancy in this reporting period.

Off-payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, clinical commissioning groups must publish information on their highly paid and/or senior off-payroll engagements. Off-payroll engagements as of 31 March 2017 for more than £220 per day and that last longer than six months are as follows:

The number that have existed:	**Number**
• For less than one year at the time of reporting	0
• For between one and two years at the time of reporting	0
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2017	0

Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017:

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

Governing Body members:

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	17

Exit packages, including special (non-contractual) payments

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

Equality disclosures

Measures are in place to ensure that all the CCG's obligations under equality, diversity and human rights legislation, and NHS Act 2006 (as amended) section 14T are complied with.

Equality and diversity obligations

We ensure that equality and diversity is a priority when planning and commissioning local healthcare. Our Equality and Diversity Strategy and action plan are designed to ensure that equality is at the heart of all that we do as commissioners and employers. The strategy and plan are reviewed on an annual basis. In addition, we produce a Public Sector Equality Duty report each year which identifies equality related data and other information about our local population. This is reviewed by our Governing Body and published on the CCG website.

Our response to the Equality Act 2010

We welcome the requirements of the Equality Act 2010. We work closely with local communities to identify specific needs and aspirations and use a range of information including equality impact assessments and targeted engagement to inform our commissioning priorities. As part of our business planning process we use detailed equality impact assessments to support decision makers to understand the potential impact of any business changes and mitigate any negative effects on protected groups.

In line with our public sector equality duty we have identified equality objectives. These are due to be reviewed and updated during 2017. In addition, we are working with health partners across Kirklees to deliver the Equality Delivery System (EDS2) using a new equality panel model to engage local stakeholders in assessing our performance and helping us to develop new equality objectives and actions. All CCG staff and Governing Body members participate in equality and diversity training appropriate to their role.

Policies

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

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

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

Training

All staff and Governing Body members are regularly reminded of their responsibility to complete mandatory training, which includes equality and diversity elements.

Compliance with the public sector equality duty

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

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

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

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

- Active membership of the Kirklees Health and Wellbeing Board
- Active engagement in the development of the Joint Health and Wellbeing Strategy
- Inclusion of 'impact on health inequalities' as one of the key criteria for weighting commissioning decisions
- Testing our five year strategic plan and operational plan against the Kirklees Joint Strategic Assessment and the Joint Health and Wellbeing Strategy
- Delivering the EDS2 annually
- Integrating equality impact assessments into the business planning process

- Setting out our equality objectives.

Equality objectives

In line with our Public Sector Equality Duty we have agreed three equality objectives for the period of 2013-2017. Our objectives are:

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

A progress update on these objectives can be found in our Public Sector Equality Duty report 2017 on the CCG website. A new set of equality objectives will be agreed in 2017 following input from local stakeholders

Disabled employees

The CCG takes a positive approach to ensure all employees are treated fairly. We have a range of policies in place and all staff undertake mandatory training which includes modules on equality and diversity legislation. We recognise that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments. The implementation of reasonable adjustments, in partnership with the affected staff member, ensures that disabled employees are fully supported to achieve their potential.

[Page left intentionally blank]

Parliamentary accountability and audit report

NHS North Kirklees CCG is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in the Accountability Report. An audit certificate and report is also included in this Annual Report.

Richard Parry
Accountable Officer
24 May 2017

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

We have audited the financial statements of NHS North Kirklees CCG for the year ended 31 March 2017, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cashflows and related notes, 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 NHS North Kirklees CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body of the CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, 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 2017.

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 2017 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

Basis for qualified opinion on regularity

The CCG reported a deficit of £2.8 million in its financial statements for the year ending 31 March 2017, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by NHS England.

Qualified Opinion on regularity

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity paragraph, in all material respects the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions in the financial statements 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 issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

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

Other matters on which we are required to report by exception - Referral to Secretary of State

We have a duty under the Local Audit and Accountability Act 2014 to refer the matter to the Secretary of State if we have a reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

On 9 May 2017 we wrote to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to a breach of its revenue resource limit by £2.8 million for the year ended 31 March 2017, which we have reason to believe exceeded the CCG's statutory powers.

Other matters on which we report by exception - Adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

In considering the CCG's arrangements for securing sustainable resource deployment, we identified the following matters:

- The CCG reported a deficit of £2.8 million in its financial statements for the year ending 31 March 2017 resulting in a cumulative deficit position of £2.8 million;
- The CCG has not yet succeeded in addressing the underlying deficit in its budget and is forecasting a further deficit of approximately £2.1 million in 2017/18, which is awaiting approval from NHS England; and
- Whilst the CCG is forecasting a surplus of £1.3 million in 2018/19, they will remain in a cumulative deficit at the end of the Spending Review period.

Except for the matters referred to above we are satisfied that the CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Certificate

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

Timothy Cutler
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1, St. Peter's Square
Manchester
M2 3AE

30 May 2017

ANNUAL ACCOUNTS

Data entered below will be used throughout the workbook:

Entity name:	North Kirklees Clinical Commissioning Group
This year	2016-17
Last year	2015-16
This year ended	31-March-2017
Last year ended	31-March-2016
This year commencing:	01-April-2016
Last year commencing:	01-April-2015

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(2,309)	(678)
Other operating income	2	(30,174)	(26,862)
Total operating income		**(32,483)**	**(27,540)**
Staff costs	4	5,082	3,662
Purchase of goods and services	5	276,753	259,749
Depreciation and impairment charges	5	34	31
Provision expense	5	0	0
Other Operating Expenditure	5	1,450	3,318
Total operating expenditure		**283,318**	**266,761**
Net Operating Expenditure		**250,835**	**239,221**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**250,835**	**239,221**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**250,835**	**239,221**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2017		**250,835**	**239,221**

The notes on pages 7 to 40 form part of this statement

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	13	179	158
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		179	158
Current assets:			
Inventories	16	1,032	738
Trade and other receivables	17	5,637	3,523
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	165	120
Total current assets		**6,834**	4,381
Non-current assets held for sale	21	0	0
Total current assets		**6,834**	4,381
Total assets		**7,013**	4,540
Current liabilities			
Trade and other payables	23	(20,421)	(16,810)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(20,421)**	(16,810)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(13,408)**	(12,270)
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		**(13,408)**	(12,270)
Financed by Taxpayers' Equity			
General fund		(13,408)	(12,270)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(13,408)**	(12,270)

The notes on pages 7 to 40 form part of this statement

The financial statements on pages 3 to 6 were approved by the Governing Body on 24TH May 2017 and signed on its behalf by:

Richard Parry
Accountable Officer
24th May 2017

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	(12,270)	0	0	**(12,270)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2017	**(12,270)**	**0**	**0**	**(12,270)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(250,835)			(250,835)
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	**(250,835)**	**0**	**0**	**(250,835)**
Net funding	249,698	0	0	249,698
Balance at 31 March 2017	**(13,408)**	**0**	**0**	**(13,408)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(11,768)**	**0**	**0**	**(11,768)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2016	**(11,768)**	**0**	**0**	**(11,768)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(239,221)			(239,221)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(239,221)**	**0**	**0**	**(239,221)**
Net funding	238,719	0	0	238,719
Balance at 31 March 2016	**(12,270)**	**0**	**0**	**(12,270)**

The notes on pages 7 to 40 form part of this statement

Statement of Cash Flows for the year ended
31 March 2017

	Note	**2016-17** **£'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(250,835)	(239,221)
Depreciation and amortisation	5	34	31
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		(294)	(438)
(Increase)/decrease in trade & other receivables	17	(2,114)	29
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,612	1,424
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		**(249,598)**	(238,175)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(55)	(60)
(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		**(55)**	(60)
Net Cash Inflow (Outflow) before Financing		**(249,653)**	(238,235)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		249,698	238,719
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		**249,698**	238,719
Net Increase (Decrease) in Cash & Cash Equivalents	20	**45**	484
Cash & Cash Equivalents at the Beginning of the Financial Year		**120**	(364)
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		**165**	120

The notes on pages 7 to 40 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 Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

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

1.3 **Acquisitions & Discontinued Operations**

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

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

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**

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

1.7.2 **Key Sources of Estimation Uncertainty**

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

1.8 **Revenue**

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.9.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.10 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.11.2 **Valuation**

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

Notes to the financial statements

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.

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 **Donated Assets**

We do not hold any donated assets.

1.15 **Government Grants**

We do not have any government grants.

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

The CCG does not have any non-current assets held for sale.

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

The CCG is not a lessor

1.18 **Private Finance Initiative Transactions**

We do not have any PFI or LIFT transactions.

1.19 **Inventories**

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

1.20 **Cash & Cash Equivalents**

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

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

1.21 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (previously: minus 0.80%)

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

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

1.22 **Clinical Negligence Costs**

The NHS 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**

We do not have any transactions relating to this scheme.

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.

Notes to the financial statements

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.27 **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.

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.

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

1.33 **Subsidiaries**

We do not have any subsidiaries.

1.34 **Associates**

We do not have any associates

1.35 **Joint Ventures**

We do not have any joint ventures

1.36 **Joint Operations**

We do not have any joint operations

1.37 **Research & Development**

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 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	828	327	501	746
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	2,305	7	2,298	678
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	29,346	8	29,338	26,116
Total other operating revenue	**32,483**	**345**	**32,138**	**27,540**

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

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

Other revenue includes £27M Continuing healthcare income and £1.4M NHS Property Services income from Greater Huddersfield Clinical Commissioning Group. This is a recharge to Greater Huddersfield to recover their proportion of the cost.

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	32,483	345	32,138	27,540
From sale of goods	0	0	0	0
Total	**32,483**	**345**	**32,138**	**27,540**

4. Employee benefits and staff numbers

4.1.1 Employee benefits	2016-17	Total	
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	4,414	2,684	1,730
Social security costs	321	278	43
Employer Contributions to NHS Pension scheme	347	342	4
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**5,082**	**3,304**	**1,778**
Less recoveries in respect of employee benefits (note 4.1.2)	(828)	(821)	(7)
Total - Net admin employee benefits including capitalised costs	**4,254**	**2,483**	**1,771**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**4,254**	**2,483**	**1,771**

4.1.1 Employee benefits	2015-16	Total	
	Total £'000	**Permanent Employees £'000**	**Other £'000**
Employee Benefits			
Salaries and wages	3,110	2,634	476
Social security costs	228	219	8
Employer Contributions to NHS Pension scheme	325	318	7
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**3,662**	**3,171**	**491**
Less recoveries in respect of employee benefits (note 4.1.2)	(746)	(746)	0
Total - Net admin employee benefits including capitalised costs	**2,916**	**2,425**	**491**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,916**	**2,425**	**491**

4.1.2 Recoveries in respect of employee benefits	2016-17			2015-16
	Total £'000	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits - Revenue				
Salaries and wages	(674)	(668)	(7)	(625)
Social security costs	(69)	(69)	0	(48)
Employer contributions to the NHS Pension Scheme	(85)	(85)	0	(73)
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	**(828)**	**(821)**	**(7)**	**(746)**

4.2 Average number of people employed

	2016-17			2015-16
	Total Number	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**98**	**82**	**16**	**86**
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

	2016-17 Number	**2015-16 Number**
Total Days Lost	552	486
Total Staff Years	82	79
Average working Days Lost	7	6

	2016-17 Number	2015-16 **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

There have been no exit packages agreed during the financial year.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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 Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers' contributions of £347,000 were payable to the NHS Pensions Scheme (2015-16: £325,000) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	4,817	2,432	2,385	3,395
Executive governing body members	265	265	0	267
Total gross employee benefits	**5,082**	**2,697**	**2,385**	**3,662**
Other costs				
Services from other CCGs and NHS England	917	175	742	3,892
Services from foundation trusts	28,383	197	28,186	26,998
Services from other NHS trusts	126,698	0	126,698	121,943
Services from other WGA bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	79,846	0	79,846	72,245
Chair and Non Executive Members	543	543	0	474
Supplies and services – clinical	1,180	0	1,180	1,173
Supplies and services – general	39	39	0	9
Consultancy services	0	0	0	0
Establishment	966	379	587	186
Transport	3	3	0	4
Premises	3,640	118	3,523	2,173
Impairments and reversals of receivables	0	0	0	0
Inventories written down and consumed	0	0	0	0
Depreciation	34	34	0	31
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	54	54	0	57
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	32,991	0	32,991	30,740
Pharmaceutical services	0	0	0	0
General ophthalmic services	125	0	125	66
GPMS/APMS and PCTMS	1,424	0	1,424	1,279
Other professional fees excl. audit	48	42	5	35
Grants to Other bodies	800	0	800	631
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	30	30	0	0
Education and training	31	16	16	99
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies		0	0	0
CHC Risk Pool contributions	409	0	409	1,023
Other expenditure	77	0	77	40
Total other costs	**278,236**	**1,630**	**276,607**	**263,098**
Total operating expenses	**283,318**	**4,327**	**278,992**	**266,760**

6.1 Better Payment Practice Code

Measure of compliance	**2016-17 Number**	**2016-17 £'000**	2015-16 **Number**	2015-16 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	19,365	89,582	17,251	76,763
Total Non-NHS Trade Invoices paid within target	17,902	83,745	15,404	67,376
Percentage of Non-NHS Trade invoices paid within target	**92.4%**	**93.5%**	**89.3%**	**87.8%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,235	156,120	2,181	153,330
Total NHS Trade Invoices Paid within target	2,054	154,460	1,930	147,385
Percentage of NHS Trade Invoices paid within target	**91.9%**	**98.9%**	**88.5%**	**96.1%**

Compliance means that the CCG must meet the target of 95% of invoices paid (by the bank automated credit system or date and issue of a cheque) within thirty days or within agreed contract terms.

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

The CCG has not made any payments under this legislation.

7 Income Generation Activities

The CCG does not undertake any income generation activities.

8. Investment revenue

The CCG does not have any investment revenue.

9. Other gains and losses

The CCG does not have any gains and losses.

10. Finance costs

The CCG does not have any finance costs.

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

We do not have any functions that transferred to or from another body to report.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	0	3,599	0	**3,599**	0	2,126	0	**2,126**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**3,599**	**0**	**3,599**	**0**	**2,126**	**0**	**2,126**

Whilst our arrangements with NHS Property Services Limited fell within the definition of operating leases, rental charge for future years has not yet been agreed. Consequently this note does not include future minimum lease payments for the arrangements only.

12.1.2 Future minimum lease payments

	2016-17				2015-16			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	0	83	0	**83**	0	83	0	**83**
Between one and five years	0	79	0	**79**	0	162	0	**162**
After five years	0	0	0	**0**	0	-	0	**0**
Total	**0**	**162**	**0**	**162**	**0**	**245**	**0**	**245**

Future minimum payments relate to the lease of Empire House, Dewsbury.

12.2 As lessor

The CCG is not a lessor.

13 Property, plant and equipment

2016-17	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction and payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Cost or valuation at 01 April 2016	0	0	0	0	0	0	177	179	356
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	55	0	55
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**232**	**179**	**411**
Depreciation 01 April 2016	0	0	0	0	0	0	82	116	198
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	24	10	34
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**106**	**126**	**232**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**126**	**53**	**179**
Purchased	0	0	0	0	0	0	126	53	179
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**126**	**53**	**179**
Asset financing:									
Owned	0	0	0	0	0	0	126	53	179
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**126**	**53**	**179**

Revaluation Reserve Balance for Property, Plant & Equipment

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

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The CCG does not have any assets under construction.

13.2 Donated assets

The CCG does not have any donated assets.

13.3 Government granted assets

The CCG does not have any government granted assets.

13.4 Property revaluation

The CCG does not have any properties.

13 Property, plant and equipment cont'd

13.5 Compensation from third parties

The CCG does not have any compensation from third parties.

13.6 Write downs to recoverable amount

The CCG does not have any write downs or reversals of pervious write downs.

13.7 Temporarily idle assets

13.8 Cost or valuation of fully depreciated assets

The CCG does not have any fully depreciated assets.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	0	3
Furniture & fittings	0	6

14 Intangible non-current assets

The CCG does not have any intangible non-current assets.

15 Investment property

The CCG does not have investment property.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2016	0	0	0	0	0	738	738
Additions	0	0	0	0	0	294	294
Inventories recognised as an expense in the period	0	0	0	0	0	0	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to the statement of comprehensive net expenditure	0	0	0	0	0	0	0
Transfer (to) from -Goods for resale	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**1,032**	**1,032**

17 Trade and other receivables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	571	0	54	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	126	0	3	0
NHS accrued income	246	0	62	0
Non-NHS and Other WGA receivables: Revenue	304	0	250	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	116	0	171	0
Non-NHS and Other WGA accrued income	4,194	0	2,854	0
Provision for the impairment of receivables	0	0	0	0
VAT	80	0	129	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables and accruals	0	0	0	0
Total Trade & other receivables	**5,637**	**0**	**3,523**	**0**
Total current and non current	**5,637**		**3,523**	
Included above:				
Prepaid pensions contributions	0		0	

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

17.1 Receivables past their due date but not impaired	**2016-17 £'000**	2015-16 £'000
By up to three months	642	136
By three to six months	6	0
By more than six months	139	85
Total	**787**	**221**

2015-16 Receivables past their due date by up to three months has been restated by (-) £80k (was £216k) as this was not due at the statement date.

£428k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG does not hold any collateral against receivables outstanding at the 31 March 2017.

17.2 Provision for impairment of receivables

The CCG does not have a provision for impairment of receivables.

18 Other financial assets

The CCG does not have other financial assets.

19 Other current assets

The CCG does not have any other current assets.

20 Cash and cash equivalents

	2016-17	2015-16
	£'000	£'000
Balance at 01 April 2016	120	(364)
Net change in year	45	484
Balance at 31 March 2017	**165**	**120**
Made up of:		
Cash with the Government Banking Service	165	120
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	**165**	**120**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**165**	**120**

The CCG doesnot hold any money on behalf of patients.

21 Non-current assets held for sale

The CCG does not have any non-current assets held for sale.

22 Analysis of impairments and reversals

The CCG does not have impairments or reversals.

23 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,802	0	1,627	0
NHS payables: capital	0	0	0	0
NHS accruals	665	0	302	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	11,189	0	8,601	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	5,338	0	5,667	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	48	0	41	0
VAT	0	0	0	0
Tax	39	0	39	0
Payments received on account	0	0	0	0
Other payables and accruals	340	0	533	0
Total Trade & Other Payables	**20,421**	**0**	**16,810**	**0**
Total current and non-current	**20,421**		**16,810**	

Other payables include £57k outstanding pension contributions at 31 March 2017, (2015-16 £53k).

24 Other financial liabilities

The CCG does not have any other financial liabilities.

25 Other liabilities

The CCG does not have any other liabilities.

26 Borrowings

The CCG does not have any borrowings/bank overdraft.

27 Private finance initiative, LIFT and other service concession arrangements

The CCG does not have any private finance initiatives, LIFT and other service concession agreements.

28 Finance lease obligations

The CCG does not have any finance lease obligations.

29 Finance lease receivables

The CCG does not hold any finance leases.

30 Provisions

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG.

The total value of legacy NHS Continuing Healthcare accounted for by NHS England on behalf of this CCG at 31 March 2017 is £819K, (2015-16 £1,471k).

31 Contingencies

The CCG does not have any contingent assets or liabilities.

32 Commitments

32.1 Capital commitments

The CCG does not have any capital commitments.

32.2 Other financial commitments

The CCG does not have any other financial commitments.

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Clinical Commissioning Group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Clinical Commissioning Group and internal auditors.

33.1.1 Currency risk

The NHS Clinical Commissioning Group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

NHS Clinical Commissioning Group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Clinical Commissioning Group draws down cash to cover expenditure, as the need arises. The NHS Clinical Commissioning Group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2016-17 £'000	**Loans and Receivables 2016-17 £'000**	**Available for Sale 2016-17 £'000**	**Total 2016-17 £'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	817	0	817
· Non-NHS	0	4,499	0	4,499
Cash at bank and in hand	0	165	0	165
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**5,481**	**0**	**5,481**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	115	0	115
· Non-NHS	0	3,104	0	3,104
Cash at bank and in hand	0	120	0	120
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**3,340**	**0**	**3,340**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2016-17 £'000	**Other 2016-17 £'000**	**Total 2016-17 £'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,467	3,467
· Non-NHS	0	16,867	16,867
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**20,334**	**20,334**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	1,930	1,930
· Non-NHS	0	14,800	14,800
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2017	**0**	**16,730**	**16,730**

34 Operating segments

North Kirklees CCG is a commissioner of healthcare services for the population of North Kirklees. This is our only operating segment and the Governing body routinely receives financial performance at this level. This means that no disclosure in respect of operating segments is required under IFRS 8.

IFRS 8 also requires entity wide disclosure of information about income from major customers. To comply with these requirements we have provided additional narrative disclosure in Note 2 - Other Operating Income.

35 Pooled budgets

35.1 Community Equipment Service

North Kirklees Clinical Commissioning Group has entered into a pooled budget with Greater Huddersfield Clinical Commissioning Group and Kirklees Metropolitan Council.
Under the arrangement funds are pooled under Section 75 of the NHSE Act 2006 for the community equipment service.

The clinical commissioning group's and consolidated group's share of the income and expenditure handled by the pooled budget in this financial year are shown below.

	2016-17 £000	2015-16 £000
Gross Funding		
North Kirklees Clinical Commissioning Group	740	687
Greater Huddersfield Clinical Commissioning Group	952	885
Kirklees Metropolitan Council	1,192	1,845
	2,884	**3,417**
Add Balance B/Fwd From Previous Year	805	771
Add B/Fwd surplus adjustment	0	0
Total Funding	**3,689**	**4,188**
Expenditure		
Equipment And Overheads	2,798	3,233
Management Overheads	200	150
Total Expenditure	**2,998**	**3,383**
Net (Surplus)/Deficit	**(690)**	**(805)**

35.2 Better Care Fund

On 1st April 2015 North Kirklees Clinical Commissioning Group has entered into a pooled budget arrangement for Better Care Fund with Greater Huddersfield Clinical Commissioning Group and Kirklees Metropolitan Council. The service is hosted by Kirklees Metropolitan Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

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

	2016-17 £'000	2015-16 £'000
Gross Funding		
North Kirklees Clinical Commissioning Group	11,878	11,858
Greater Huddersfield Clinical Commissioning Group	14,726	14,697
Kirklees Metropolitan Council	2,483	2,398
Total Funding	**29,087**	**28,953**
Expenditure		
North Kirklees Clinical Commissioning Group	4,458	5,068
Greater Huddersfield Clinical Commissioning Group	5,844	6,627
Kirklees Metropolitan Council	18,785	17,258
Total Expenditure	**29,087**	**28,953**
Net (Surplus)/Deficit	**0**	**0**

As at 31st March 2017 North Kirklees CCG have included £712k accruals for Better Care Fund

36 NHS Lift investments

The CCG does not have any LIFT investments.

37 Related party transactions

Details of related party transactions with individuals are as follows:

	Payments to Related Party 2016-17 £'000	Payments to Related Party 2015-16 £'000
Albion Street Surger (Dr A Jabbar)	24	25
Brookroyd House (Dr D Kelly)	69	86
Cherry Tree Surgery (Dr A Jabbar)	7	20
Dr Mahmood and Partners (Dr Y Mahmood & Rachel Kilburn)	21	0
Park View Surgery (Dr Y Mahmood & Rachel Kilburn)	69	80
Greenway Practice (Dr A J Cameron)	33	67
Healds Road Surgery (Dr N Ghafoor)	54	78
Liversedge Medical Centre (Dr N Ghafoor)	21	27
Mount Pleasant Medical Centre (Dr K Naeem)	71	110

The remuneration of individual executive governing body members is disclosed with the CCGs annual report page **52**.
There were no outstanding balances with members as at 31st March 2017 or 31st March 2016.

Related party transactions to Curo Health Limited during 16/17 totalled £719k, of which a balance of £122k was unpaid at 31st March 2017. This relates to 10% of the balance of the Quality Access Scheme (£71k) and Practice support and development (£51k).
All 29 GP Practices are members and have shares in Curo Health Limited.

Richard Parry is the Chief Officer of North Kirklees Clinical Commissioning Group and the Director for Commissioning. Public Health and Adult Social Care for Kirklees Metropolitan Council but has no material transactions.

Pat Keane is the Chief Operating Officer of both North Kirklees Clinical Commissioning Group and Wakefield Clinical Commissioning Group but has no material transactions.

NHS England is the parent entity and is regarded as a related party. The Department of Health as the parent department is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. These entities are listed below.

	2016-17 £'000	2015-16 £'000
Mid Yorkshire Hospital NHS Trust	108,470	104,561
Calderdale and Huddersfield NHS Foundation Trust	6,606	5,375
Leeds Teaching Hospitals NHS Trust	8,541	7,929
South West Yorkshire Partnerships NHS Foundation Trust	17,314	17,496
Bradford Hospitals NHS Teaching Trust	2,640	2,685
Yorkshire Ambulance Service NHS Trust	9,373	9,090
Prescription Pricing Authority	32,991	30,740
Kirklees MBC	18,977	15,047

38 Events after the end of the reporting period

From 1st April 2017, North Kirklees CCG has been delegated responsibility for commissioning Primary Medical Services from NHS England. The expected budget to be delegated is approximately £24.8m, this is a non-adjusting event after the end of the reporting period.

From 1st April 2017, Greater Huddersfield CCG will enter into a new pooled budget arrangement with Kirklees MBC and North Kirklees Clinical Commissioning Group for Healthy Child Programme Expenditure. The expected budget to be delegated is approximately £11.3m of which North Kirklees Clinical Commissioning Group will contribute £1.5m.

39 Loses as special payments

There have been no losses or special payments during 2016/17.

40 Third party assets

The clinical commissioning group does not have any cash or cash equivalents which relate to monies held by the clinical commissioning group on behalf of other parties.

41 Financial performance targets

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

	2016-17 Target	**2016-17 Performance**	2015-16 Target	2015-16 Performance
Expenditure not to exceed income	280,551	283,373	270,529	266,821
Capital resource use does not exceed the amount specified in Directions	55	55	60	60
Revenue resource use does not exceed the amount specified in Directions	248,013	248,013	242,929	242,929
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	4,138	3,982	4,301	3,923

In 2016/17, the CCG overspent by £2,822k, the CCG plans to return to return to a surplus position by 2019/20.

42 Impact of IFRS

There is no impact to the clinical commissioning groups accounts as a result of adopting IFRS.

43 Analysis of charitable reserves

The CCG does not hold any charitable reserves.

NHS North Kirklees Clinical Commissioning Group
4th Floor Empire House, Wakefield Road, Dewsbury, WF12 8DJ
Tel: 01924 504900 www.northkirkleesccg.nhs.uk