FORMAT FOR PAPERS FOR DISCUSSION AT THE HEALTH AND WELLBEING BOARD

KIRKLEES HEALTH & WELLBEING BOARD

MEETING DATE: 28th September 2017

TITLE OF PAPER: NHS Greater Huddersfield CCG – Annual Report & Accounts 2016/17

1. Purpose of paper

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

2. Background

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

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

Whilst the guidance sets the minimum content of the Annual Report & Accounts, the CCG must take ownership of the document and ensure that additional information is included where necessary to reflect the position of the CCG within the community and give sufficient information to meet the requirements of public accountability.

3. Proposal

The purpose of this report is to formally present Greater Huddersfield Clinical Commissioning Group 2016/17 Annual Report and Accounts to the Health & Well-Being Board.

4. Financial Implications

There are no financial implications resulting from this report.
The report contains the CCG's Annual Accounts, which set out the CCG's financial position as at the end of 2016/17.

5. Sign off

Carol McKenna, Chief Officer, Greater Huddersfield CCG (20/9/17)

6. Next Steps

No identified next steps. The Annual Report & Accounts 2016/17 are already available to view on the CCG's website at www.greaterhuddersfieldccg.nhs.uk

7. Recommendations

That the Board **NOTE** the CCG's Annual Report & Accounts 2016/17.

8. Contact Officer

Laura Ellis, Governance & Corporate Manager, Greater Huddersfield CCG
Tel: 01484 464324 E-mail: laura.ellis@greaterhuddersfieldccg.nhs.uk

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report and Accounts 2016/17

Contents

Chair's Introduction

Welcome to our 2016/17 report. The CCG is now four years old and really starting to make changes to our healthcare system. Our last year was dominated by our public consultation on reconfiguring hospital and community services. We welcomed the opportunity to explain our plans to our population and generally our proposals are understood even if they are not universally agreed with. We still passionately want the best healthcare for Greater Huddersfield residents and ALL our plans have that aim.

We have had a difficult year financially and for the first time have not reached our financial plan for the year. We are not the only CCG in this position and as a result we are now under increased scrutiny from NHS England who want to be assured we are doing everything we can to balance the books whilst maintaining high quality, accessible services. It is for this reason you will have seen some of our latest initiatives to prioritise our spending e.g. stopping gluten free prescribing. We continue to spend more money on health services for the residents of Greater Huddersfield year on year, but increased costs and demand means we have had to reduce our spending in some areas.

We have had a strong focus on financial recovery this year and welcomed a new Chief Finance Officer, Ian Currell. Ian has a very strong NHS financial background having worked in a number of roles including NHS England. He has overseen a huge effort by all our CCG employees to focus on our finances and we are confident he will lead our CCG's recovery to financial stability.

We have had a busy year implementing our Primary Care Strategy which was signed off in April 2016. We see this as fundamental in helping our GP practices survive into the future as demand rises and numbers of GPs fall. We are committed to supporting vulnerable practices who are finding workload increasing and trying to ensure all patients get a consistent service from their GP practice.

We have continued to work closely with our patients, not just in our consultation but also via our community assets, our Patient Reference Group Network and other engagement events. We have responded to unprecedented information requests from members of the public and have continued to have a few people attend our public Governing Body meetings. We always welcome public interest in our work.

It has been well reported in the press about the struggles facing the NHS and we are no different here in Greater Huddersfield. I strongly believe that our plans and work we have done during this year stand us in good stead to meet these challenges. We have a dedicated team and member practices and I am confident we will work together to ensure that people of Greater Huddersfield continue to have access to high quality health care.

During 2016/17, I applied for and was re-appointed for another 3 year term of office as Chair. I am delighted to be able to continue in this role and look forward to building on the work of both the CCG and the wider health and social care system in the coming year.

Dr Steve Ollerton
Chair, NHS Greater Huddersfield CCG

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report 2016/17

The Performance Report

Carol McKenna
Accountable Officer

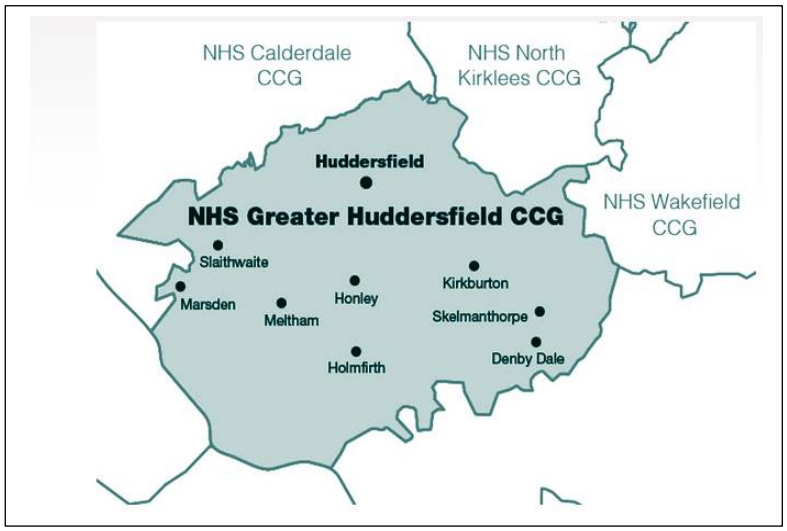
25 May 2017

The Performance Report - Overview

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

About Us – Our Purpose and Activities

Greater Huddersfield Clinical Commissioning Group (CCG) is a membership organisation of 37 general practices. We are led by local GPs and it is our role to commission (plan and buy) the majority of hospital and community health services for our local population. 247,000 people live in our area (approximately 58% of the Kirklees Council area), and the map shows the area we cover.



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

Our Population and Their Needs[1]

Our population is increasing and will continue to grow, especially in the older age groups. This is creating health and social care challenges as more people live longer with long term conditions, and brings economic and social challenges as the proportion of working age people reduces.

Headlines from the **Kirklees Joint Strategic Needs Assessment** (2013):

- **Infant deaths** under 1 year have reduced. They are still slightly higher than the national rate but falling faster than nationally – maternal smoking rates continue to have an impact on the higher rates.

[1] Kirklees Joint Strategic Needs Assessment 2013

- **Cancer** remains the most common cause of death in those aged under 75, although this is improving. Cancer survival rates are also improving although lung cancer survival remains low. Prevention is crucial, including reducing smoking rates and improving diet, along with raising awareness of symptoms and earlier diagnosis.
- **Cardiovascular disease** remains the second biggest cause of premature death although the rate has reduced since 2005. Most of these deaths could be prevented by making lifestyle changes including reducing smoking rates, improving diet, being more active and reducing alcohol misuse.
- **Chronic Obstructive Pulmonary Disease** (COPD) is the fifth biggest killer in the UK and the second most common cause of emergency admission to hospital. The self-reported rate of COPD is 2.5%, but it is likely the actual rate is around twice this. Smoking causes 4 in 5 cases.
- 1 in 5 adults report suffering from **depression, anxiety or other mental health** condition. The emotional health and wellbeing of 14 year olds is a significant issue, especially in the Holme Valley, Denby Dale and Kirkburton.
- More than half of adults are **overweight or obese**. Among children, obesity rates increase as they get older and almost 1 in 5 10-11 years olds are obese. Rising obesity rates pose risks to the long term health of the population in terms of diabetes, cardio-vascular disease and cancer.
- Almost 1 in 3 adults live with a **long term limiting condition**, a rising trend.
- 1 in 6 14 year olds and 1 in 10 adults report having **asthma**.
- Rates of **TB and sexually transmitted infections** are rising, and early diagnosis of HIV remains a challenge.
- Uptake of **childhood immunisations** is lower than the rest of Kirklees, Yorkshire and the Humber and the national target.
- **Lifestyle choices** have a significant impact on the major causes of ill health and premature death in Greater Huddersfield. Whilst smoking rates continue to decline, there remain significant challenges, especially among women of childbearing age, children and those living in the more deprived areas. 2 in 5 14 year olds live with an adult who smokes.
- 1 in 4 adults display 3 or more **unhealthy behaviours** – a rising trend.

The Public Health Intelligence team at Kirklees Council is currently updating the above information, as part of the Kirklees Joint Strategic Assessment which is an evolving resource presenting the latest local health intelligence in a simple and informative way. This informs the commissioning strategies and plans of the CCG.

Our Vision, Values, Ambitions and Objectives

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

The CCG has also developed its own Vision, Values, Ambitions and Objectives, which were revised at the commencement of 2016/17 following engagement with CCG members, our staff and patients.

Our Vision, Values, Ambitions & Objectives

Our vision

Working together for better health

Our values

- Focusing on people
- Leading
- Working together
- Listening
- Being adaptable
- Learning

Our ambitions

- **Deliver high quality, sustainable care now and in the future.**
- **Promote self-care by empowering and supporting people.**
- **Manage within our budget.**
- **Ensure timely access to healthcare.**
- **Reduce health inequalities**

Our strategic objectives

- **Contribute to the development of a sustainable NHS workforce to support the delivery of high quality care.**
- **Build a collective sense of responsibility, amongst all those involved in health care, for the effective management of resources.**
- **Work with partners and the public to improve health awareness, emotional wellbeing, community and personal resilience.**
- **Shift healthcare spend towards community and primary care services to meet patient need and ensure value for money.**
- **Ensure appropriate use of hospital services.**
- **Improve health related experiences and outcomes for people with long term conditions, particularly those that experience significant inequalities.**
- **Reduce avoidable variation in healthcare and patient experience.**
- **Work with the Local Authority to commission a range of health and social care services.**
- **Deliver our financial plans.**
- **Invest in the health, well-being and personal development of our staff.**

Our Commissioning Intentions and Ambitions

The CCG Operational Plan sets out our ambitions for the next two years and describes how we will commission high quality health services for the people of Greater Huddersfield. It highlights the complexities in our planning footprint with our neighbouring CCGs and the challenging financial landscape. 2017/18 will be a continuation of the work we prioritised in previous years as we continue to commission services that deliver care in a timely way, closer to where people live and, as a consequence, reduce the occasions where hospital admission is required.

We face significant challenges to improve hospital and community health services, and we recognise locally that to enable us to address our local challenges there are elements which we cannot progress on our own, a collective approach over a much larger area is required to maximise the benefits for local people. These areas will be addressed at scale through the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP).

The Healthy Futures Programme was established to develop the STP and progress the underpinning work streams which will be delivered as part of it. Our local Acute Trusts are also using these principles to collaborate as providers across West Yorkshire through the West Yorkshire Association of Acute Trusts (WYAAT).

The West Yorkshire and Harrogate STP is underpinned by six place based plans. Greater Huddersfield CCG along with North Kirklees CCG and Kirklees Local Authority have co-produced the Kirklees Health and Wellbeing Plan. The plan clearly articulates the vision for the Kirklees health and social care system.

Fundamental to delivery of both the Operational Plan and the STP is the role of primary care and GP practices. As a membership organisation, we continue to work with our member practices to help make the changes required for primary care services in Huddersfield to be high quality, safe and efficient. In 2016/17 we have published our **Primary Care Strategy** and we continue to make sure this reflects the principles set out in the GP 5 year forward view.

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

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

- We don't comply with national guidance – currently the two A&Es at Halifax and Huddersfield do not comply with many of the standards for children and young people in emergency care settings. By providing an intensive care unit at each site, the Trust is not able to fully comply with NHS England's guidance on critical care workforce standards.

- Too many patients are re-admitted within 30 days – the number of patients who need to come back into our hospitals as emergency readmissions within 30 days of discharge is above the national average.
- Too many patients are admitted to hospital with a long term condition – adults with chronic illnesses in Calderdale and Greater Huddersfield are more likely to be taken into hospital than other patients in England, as are young people with asthma, diabetes and epilepsy.
- Too many patients stay longer in hospital than clinically necessary – our Delayed Transfer of Care rate is over target which means older and vulnerable people spending longer in hospital than they need to while arrangements are made to provide care and support at home or in residential and nursing care homes.
- Too many patients don't have a good experience in our hospitals – more is needed to improve the experience of patients using our hospitals, which have a higher than national average number of complaints.
- In the last 15 years there have been great advances in medical knowledge and technology and the development of increasingly sophisticated and specialist treatments and procedures – we need to make sure our health system has adapted to meet these and future advances so that patients can get the latest treatments and have the best chances of good outcomes when they become very ill.
- A number of hospital services are experiencing serious challenges in recruiting and retaining staff as well as being non-compliant or struggling to meet the Royal College of Emergency Medicine's recommendations.
- The local health economy is facing a very difficult financial situation - without change the system would become financially unstable and would not be able to afford the improvements needed to deliver consistently safe, high quality, sustainable care.

We looked very closely at the different ways that we could use the two hospitals to address the challenges we face and ensure high quality, safe, sustainable and affordable services going forward. The challenges we face mean that there is only one clinical alternative, which is to have an Urgent Care Centre and an Emergency Centre on one site and an Urgent Care Centre and a planned care hospital on one site in order to maintain quality and ensure services are safe.

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

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

In June 2016, the CCGs completed consultation on the proposed future arrangements for hospital and community health services. The Consultation Institute confirmed that the consultation fulfilled the requirements of their Quality Assurance

Process and they signed off all elements of the consultation as being consistent with their good practice standards.

Following the consultation, the Programme entered a post-consultation deliberation phase during which they considered the response to the public consultation in the context of the CCG's duties and obligations, including those in relation to Equality and Health Inequalities.

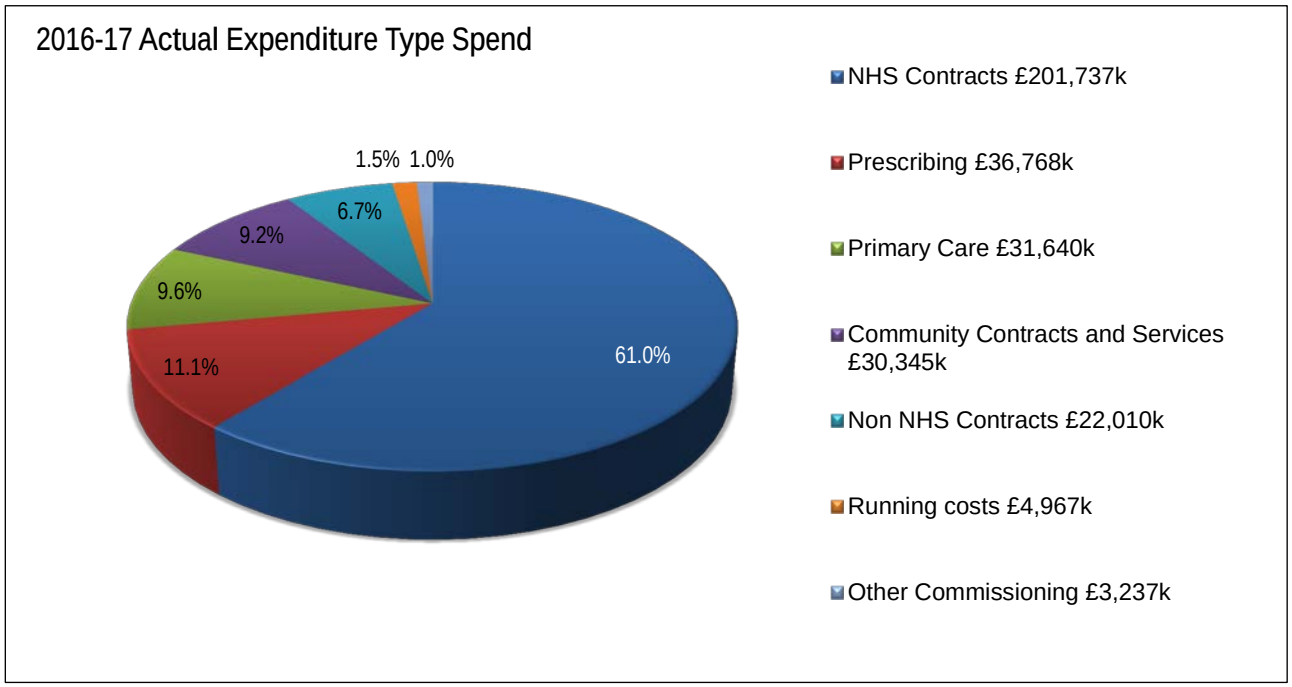
The Post-consultation deliberation phase was informed by:

- The Independent Report of findings from the consultation, which was shared with the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee and published on the CCG's website
- The independent Equality and Health Inequality Impact assessment of the consultation, which was also published on the CCG's website
- The issues and concerns raised in the response to the consultation from the Calderdale and Kirklees Joint Health Overview and Scrutiny Committee (JHOSC), which included the response from Calderdale and Kirklees Healthwatch.

In October 2016, the CCG agreed to proceed to explore implementation of the proposed changes as part of a Full Business Case. The CCG together with Calderdale CCG and CHFT are now producing the Full Business Case and associated documents.

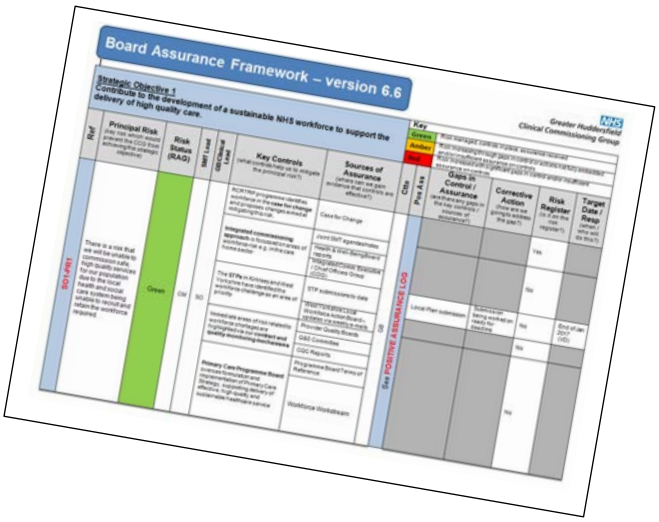
How we spend your money

During 2016/17 we invested over £330m to improve the health of local people through the commissioning of high quality services which is illustrated in the pie-chart and table of numbers below:-



Expenditure Type	£,000	%
NHS Contracts	201,737	61.0%
Prescribing	36,768	11.1%
Primary Care	31,640	9.6%
Community Contracts and Services	30,345	9.2%
Non NHS Contracts	22,010	6.7%
Running costs	4,967	1.5%
Other Commissioning	3,237	1.0%
2016-17 Total Expenditure	330,705	100.0%

Key Issues and Risks



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

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

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

Strategic Objective 1 **Contribute to the development of a sustainable NHS workforce to support the delivery of high quality care.**
• There is a risk that we will be unable to commission safe, high quality services for our population due to the local health and social care system being unable to recruit and retain the workforce required.
• There is a risk that there will be insufficient staff for effective General Practice – GPs, nurses and practice managers - due to the inability to recruit resulting in the quality of care reducing
• There is a risk that providers of commissioned NHS funded services are not subject to

the requirements set out within the NHS Standard Contract due to a contract not being in place leading to loss of leverage to ensure appropriate provider workforce is in place.
Strategic Objective 2 **Build a collective sense of responsibility, amongst all those involved in health care, for the effective management of resources.**
• There is a risk of failure to maintain and improve the quality and safety of services due to ineffective assurance resulting in harm to patients
• There is a risk that commissioning arrangements for safeguarding do not ensure providers are effectively discharging their duties due to ineffective safeguarding arrangements with partners, resulting in harm to children and adults
• There is a risk that the spending on healthcare across the health economy is not delivering the full benefit for the resource deployed resulting in patients not getting the full of the funding spent in Greater Huddersfield.
• There is a risk that we are unable to secure active participation particularly from Member Practices resulting in the CCG's inability to deliver its priorities.
Strategic Objective 3 **Work with partners and the public to improve health awareness, emotional well-being, community and personal resilience.**
• There is a risk that we are unable to secure effective partnerships to deliver shared priorities and service change
Strategic Objective 4 **Shift healthcare spend towards community and primary care services to meet patient need and ensure value for money.**
• There is a risk that the CCG will be unable to re-direct financial resource to primary and community services due to rising demand for, and increased costs in, the hospital sector.
Strategic Objective 5 **Ensure appropriate use of hospital services.**
• There is a risk that alternatives to hospital services are not utilised appropriately to optimum levels and that services continue to be accessed in hospital settings.
Strategic Objective 6 **Improve health related experiences and outcomes for people with long term conditions, particularly those that experience significant inequalities.**
• There is a risk that individuals with long term conditions will have inequitable access to services to enable to maintain mental and physical well being
Strategic Objective 7 **Reduce avoidable variation in healthcare and patient experience.**
• There is a risk that patients will be harmed from inappropriate or ineffective health care resulting in poor patient outcomes (Iatrogenic Harm)
• There is a risk of not improving and maintaining patient experience due to: - Not using patient intelligence appropriately with providers to improve that experience - Not using patient intelligence to develop commissioning plans or service specifications resulting in patient dissatisfaction
• Risk that CCG does not appropriately consider people with protected characteristics due to lack of effective processes for capturing equality and diversity information resulting in a failure to reduce variation in healthcare
Strategic Objective 8 **Work with the Local Authority to commission a range of health and social care services.**
• There is a risk that we fail to realise our integrated commissioning ambitions due to constraints such as financial positions and capacity pressures
Strategic Objective 9 **Deliver our financial plans.**

• There is a risk that the CCG will not deliver its financial plans due to increasing growth in acute activity at rates above those funded in the CCG indicative growth in allocations.
• There is a risk that the CCG will not deliver its financial plans due to not delivering its recovery plan.
Strategic Objective 10 **Invest in the health, well-being and personal development of our staff.**
• There is a risk that we are unable to recruit and retain staff with the skills required to address the increasingly complex agendas facing the CCG.
• There is a risk that staff morale and wellbeing decline due to increasingly challenging workloads and the consequences of continued pressure on running cost allocations.

Our Financial Plan for 2017/18

The plan for 2017/18 is very challenging and relies on the CCG being able to make significant levels of savings of £13.5m. Even with this level of savings the CCG is planning to spend £1.2m more than the in-year allocation it will receive in 2017/18. This will be partly offset by the £0.7m surplus carried forward from 2016/17. The CCG is aiming to achieve an in-year surplus in 2018/19. The CCG recognises that next year's plan is extremely challenging and will continue with the financial recovery process it started this year.

The savings target of £13.5m is £7m more than the equivalent target for 2016/17. The CCG has developed a significant number of schemes to deliver savings throughout the year. There is still much to do and the CCG must ensure successful implementation in order to deliver the savings target in full.

The impact of each scheme will be closely monitored and reported through governance arrangements. The most significant scheme to be implemented is a new Muscular Skeletal service pathway which will bring services into the community and closer to people's homes.

There are a number of risks that threaten delivery of our 2017/18 financial plan, these include:

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

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

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

Performance Summary

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

Demand on our hospital services continues to be a significant challenge as our population ages and emergency admissions increase. Our health economy has experienced considerable challenges, not least for A&E and the urgent care system. This has had implications for waiting times, notably the number of patients attending accident and emergency departments and waiting over four hours.

Greater Huddersfield CCG, Calderdale CCG and Calderdale and Huddersfield NHS Foundation Trust have formed the Accident and Emergency Delivery Board (A&EDB) in order to address system pressures through an integrated approach. Key partners from both the Health and Social Care economy meet monthly to discuss the current issues and agree actions to address any areas of underperformance.

The Calderdale and Huddersfield A&EDB are part of a larger pilot. The West Yorkshire Acceleration Zone (WYAZ) has been set up to deliver rapid implementation of improvements in urgent and emergency care delivery across the West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) footprint. WYAZ is the only urgent and emergency acceleration zone in the country.

We expect to learn about the benefits of supporting one health and social care system to go further, faster – and whether this approach should be rolled out to other areas of the country. WYAZ consists of three programmes of work looking at Pre-Hospital Care, Streaming and Ambulatory Care, and Flow & Discharge.

West Yorkshire has been chosen because the Healthy Futures Urgent and Emergency Care Vanguard provides a solid platform to build on. The Vanguard's vision is that 'all patients with urgent and emergency needs in West Yorkshire will get the right care in the right place, first time, every time'.

The emergency care standard of 4 hours was achieved in March 2017 by Calderdale and Huddersfield NHS Foundation Trust and performance prior to that, although not at 95%, was the best in Yorkshire and the Humber.

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

The Performance Report – Performance Analysis

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

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

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

Principles that guide the NHS

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

How the CCG Measures Performance

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

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

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

prolonged underperformance is addressed by a performance improvement plan which is monitored throughout the recovery period.

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

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

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

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

Assurance

NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The CCG assurance framework for 2016/17 sets out five components that reflect the key elements of a well led effective clinical commissioner and underpin assurance discussions between CCGs and NHS England, whilst identifying on-going ambitions for CCG development. The components include being well led; performance; financial management; planning; and delegated functions.

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

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

Domain 1: Are patients receiving clinically commissioned, high-quality services?
Domain 2: Are patients and the public actively engaged and involved?

Domain 3: Are CCG plans delivering better outcomes for patients?
Domain 4: Does the CCG have robust governance arrangements?
Domain 5: Are CCGs working in partnership with others?
Domain 6: Does the CCG have strong and robust leadership?

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

The CCG had its annual assurance meeting with NHS England on 4 May 2017; at the time of writing, the CCG had not received formal notification of the outcome of this assurance meeting.

Detail on the **My NHS Quality of Leadership indicator**, which is based on four key lines of enquiry to determine how robustly the leaders of a CCG are performing their role, can be seen on page 73. The 2016/17 year-end assessment for the CCG will be available on www.nhs.uk/service-search/Performance/Search from July 2017.

Detailed Analysis and Explanation of the CCG's Development and Performance

Referral to Treatment (RTT)

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

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

In Greater Huddersfield CCG we have consistently achieved the 18 week standard for incomplete pathways throughout the year, at both aggregate and specialty level. The year-end performance for 2016-17 was 94.1%.

Number of patients waiting more than 52 weeks

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

In 2016-17, no Greater Huddersfield CCG residents waited 52 weeks or more.

Diagnostic test wait times

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

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

In Greater Huddersfield CCG the year-end performance for 2016-17 was 1% of patients waiting 6 weeks or more for a diagnostic test.

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

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

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

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

There have been pressures on the urgent care system throughout the year to a greater extent that has been experienced in previous years. The System Resilience Group and the Urgent Care Board have come together to form the Accident & Emergency Delivery Board. This is made up of representatives from across health and social care and covers our acute footprint of Calderdale & Huddersfield NHS Foundation Trust.

The NHS Improvement Board agreed a Sustainable Transformation Fund trajectory with the Trust in relation to expected performance in 2016/17. This has been monitored and achieved each month up to and including March 2017 with the tolerance permissible and set out in the technical guidance. Commissioners are currently in discussion with the Trust, facilitated by the NHS Improvement Board, Monitor and NHS England regarding an STF trajectory for 2017/18.

Calderdale and Huddersfield NHS Foundation Trust achieved 95% in March 2017 in line with the STF trajectory, and performance throughout the year has been the best in Yorkshire and the Humber.

Cancer waits – 14 days

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

The two-week wait services ensure fast access to diagnostic tests, supporting the provision of an earlier diagnosis and assisting in improving survival rates for cancer. The standard is that 93% of patients should have a maximum two-week wait for their first outpatient appointment if referred with suspected cancer by a GP or if referred urgently with breast symptoms (where cancer is not initially suspected).

The year-end performance for 2016/17 was:

- All cancer two-week waits – 97.3%
- Two-week wait for breast symptoms – 94.8%

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

Cancer waits – 31 and 62 days

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

The standards, and Greater Huddersfield CCG 2016-17 year end performance are as follows:

- Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – 96% **(CCG performance – 99.0%)**
- Maximum 31 day wait for subsequent treatment where that treatment is surgery – 94% **(CCG performance – 99.6%)**
- Maximum 31 days wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% **(CCG performance – 100%)**
- Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% **(CCG performance – 100%)**
- Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer – 85% **(CCG performance – 86.8%)**
- Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% **(CCG performance – 90.6%)**
- Maximum 62 day wait for first definitive treatment following a consultant's decision to upgrade the priority – there is no current operational standard, however performance data is monitored and published as national statistics. **(CCG performance – 100%)**

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

Mixed Sex Accommodation (MSA) breaches

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

In 2016-17, there have been three incidents of MSA at Calderdale & Huddersfield Foundation Trust on the Huddersfield Royal Infirmary site involving five Greater Huddersfield CCG patients. Following any reports of MSA, a root cause analysis is undertaken, learning is shared throughout the Trust, and processes are put in place to mitigate any reoccurrence.

Healthcare Acquired Infections (HCAI) measure (MRSA)

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

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

There has been one reported case of MRSA at Calderdale & Huddersfield NHS Foundation Trust in 2016/17. Any reported cases of MRSA are investigated by the Trust and the Head of Health Protection to identify the root cause and to understand if the incident was avoidable. If a case is deemed avoidable, process and procedures will be put in place to mitigate the risk of any further incidents. The details of the root cause analysis are shared with the Quality & Safety Committee and action plans agreed to monitor performance throughout the year are scrutinised by the Quality Team.

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

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

The 2016/17 annual CDI objectives for the CCG were set at no more than 40 cases. The CCG is required to establish and report against monthly trajectories for CDI cases in order to ensure continued reduction.

There have been 37 reported cases in Greater Huddersfield in 2016/17. Reported cases of CDI are investigated to identify the root cause and to understand if the incident was avoidable. If a case is deemed avoidable, process and procedures will be put in place to mitigate the risk of any further incidents. The details of the root cause analysis are shared with the Quality & Safety Committee and action plans agreed to monitor performance throughout the year are scrutinised by the Quality Team.

Cancelled Operations

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

In 2016/17, there were no reported breaches of the Cancelled Operations standard at Calderdale & Huddersfield NHS Foundation Trust. The standard is monitored closely via the Contracting Group.

Mental health measure – Care Programme Approach (CPA)

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

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

As at the end of Quarter 4, Greater Huddersfield CCG had achieved 97.3%.

NHS Constitution

The dashboard over the next two pages shows performance against all NHS constitutional measures, for both the current month and year to date.

Out of the 21 reportable indicators in the NHS Constitution, 16 indicators are green, 1 amber and 4 red.

Reporting Period Mar 2016/17

NHS Constitution Rights and Pledges 2016/17

Outcome/Measure		Target/ Baseline	Period Actual	Period RAGS	YTD	YTD RAG	Direction of Travel
Referral To Treatment waiting times for non-urgent consultant-led treatment	Admitted patients to start treatment within a maximum of 18 weeks from referral	-	81.6%		83.1%		↓
	Non-admitted patients to start treatment within a maximum of 18 weeks from referral	-	97.2%		97.1%		↓
	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral	92%	94.4%	●	94.1%	●	↑
	Number of patients waiting more than 52 weeks	0	0	●	0	●	↔
Diagnostic test waiting times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	94.2%	●	99.0%	●	↓
A&E waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	97.4%	●	94.2%	●	↑
	No waits from decision to admit to admission (trolley waits) of more than 12 hours	0	0	●	0	●	↔

Cancer waits – 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with	93%	97.7%	●	97.3%	● ↑
	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms	93%	95.1%	●	94.8%	● ↑
Cancer waits – 31 Days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	98.9%	●	99.0%	● ↑
	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	100%	●	99.6%	● ↑
	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%	●	100%	● ↔
	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100%	●	100%	● ↔
Cancer waits – 62 Days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	83.6%	●	86.8%	● ↑
	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100%	●	90.6%	● ↑
	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	-	100%	●	100%	● ↔
Category A Ambulance Calls	Red/Category1 calls resulting in an emergency response arriving within 8 minutes	No data to report				
	Amber/Category 2R calls resulting in an emergency response arriving within 19 minutes*	No data to report				
	Amber/Category 2T calls resulting in an emergency response arriving within 19 minutes*	No data to report				
	All handovers between ambulance and A&E must take place within 15 minutes	95%	70.9%	●	72.3%	● ↑
	All crews should be ready to accept new calls within a further 15 minutes	95%	69.7%	●	73.0%	● ↓
Mixed Sex Accommodation	Minimise breaches	0	0	●	3	● ↑
MRSA	Number of MRSA reported infections	0	0	●	1	● ↑
C_Diff	Number of C-Diff blood stream infections	40	3	●	37	● ↑
Cancelled Operations	All patients who have operations cancelled, on or after the day of admission, for non-clinical reasons to be offered another binding date within 28 days	0	Q4 0	●	0	● ↔
Mental Health	Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge	95%	Q4 96.7%	●	97.3%	● ↓

Business Intelligence

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

The Consortium provides a business intelligence service to support the performance and contracting functions within Greater Huddersfield CCG. eMBED is led by Kier and run in partnership with Dr Foster, BDO and Engine. The eMBED team combines partners who each bring longstanding public and health sector experience and a range of specialist skills.

eMBED provide the CCG with a number of routine reports to help monitor performance, numerous dashboards and an ad hoc service for data requirements. 2016-17 has been a challenging year for eMBED in terms of delivering the tailored service that CCGs commissioned and although improvements have been made the team still struggles to maintain an efficient service.

Better Care Fund

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

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

Vision for Health and Care Services in Kirklees

Our overall vision as set out in the Joint Health and Wellbeing Strategy (JHWS) is that for everyone who lives in Kirklees:

> *"By 2020, no matter where they live, people in Kirklees live their lives confidently, in better health, for longer and experience less inequality."*

The JHWS recognises that whilst there have been overall improvements in local health and wellbeing there are still significant health and care challenges set out in the JSNA. The most recent refresh of the JHWS has sharpened the focus on creating an integrated health and social care system that is capable to responding to these challenges.

The Health and Wellbeing Board is leading the development of the Kirklees Sustainability and Transformation Plan. The draft objectives are shown in the diagram below:

NHS
Greater Huddersfield
Clinical Commissioning Group

Kirklees 2020 Vision

Objectives for local people

- ✓ People in Kirklees are as well as possible for as long as possible, both physically and mentally
- ✓ People can control and manage life challenges and are able to do as much for themselves and each other as possible
- ✓ People have a safe, warm, affordable home in a decent physical environment within a supportive community and a strong, sustainable economy
- ✓ People take up opportunities that have a positive impact on their health and wellbeing
- ✓ People who are informal carers are identified, supported and involved
- ✓ People experience high quality seamless health and social care that puts their individual needs, choices and aspirations at the heart of their care and support

Objectives for local services

- ➢ The local health and social care system is affordable and sustainable, and investment is rebalanced across the system towards activity in community settings and in peoples own homes
- ➢ Integrated service delivery across primary, community and social care focusses on prevention and early intervention, and are available 24 hours a day and 7 days a week where relevant
- ➢ Strategic planning, commissioning, intelligence, technology, workforce and community planning are fully integrated
- ➢ New solutions are created through innovation and creative collaboration locally, regionally and nationally

NHS
North Kirklees
Clinical Commissioning Group

.

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

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

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

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

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

1. Non-elective admissions:
   We will monitor the number of Non elective admissions (emergency admissions), where patients are admitted to hospital. A reduction the number of emergency

admissions is expected as a result of the services in place to avoid a patient being unexpectedly admitted to hospital.

2. Permanent admissions of older people (65 and over) to residential and nursing care homes:
   Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.

   The outcome expected is to reduce inappropriate admissions of older people (65+) in to residential care.

3. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
   The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.

   The outcome expected is to Increase the effectiveness of the services whilst ensuring that those offered a service does not decrease. Improving the effectiveness of these services is a good measure of delaying dependency, the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.

4. Delayed transfers of care from hospital: (DToC)
   Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

   The focus is to identify patients who are in the wrong care setting for their current level of need and it includes patients waiting for external transfer in all NHS settings, irrespective of who is responsible for the delay.

   A patient is ready for transfer when:
   a. A clinical decision has been made that patient is ready for transfer **AND**
   b. A multi-disciplinary team decision has been made that patient is ready for transfer **AND**
   c. The patient is safe to discharge/transfer.

   We will monitor the number of delayed transfers; the expectation is that the number will reduce. There is variance across the Kirklees footprint; the performance at CHFT meets the national standard. Performance at Mid

Yorkshire Hospitals Trust is challenging and impacts the Kirklees overall performance.

5. Dementia diagnosis

   Improving the ability of people living with dementia to cope with symptoms, access to treatment and care and support. The planning guidance states that the national dementia diagnosis rate to two thirds (66.7%) should be achieved and sustained through 2016/17.

   A timely diagnosis enables people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease. A timely diagnosis enables primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

   The outcome expected is that we maintain the 66.7% standard.

6. Patient / service user experience Everyone Involved in my Care knows my Story:

   (i) Improvement in response Rate on completion of care episode,

   (ii) Increase in % of patients/carers reporting satisfaction about the level of information services have about them on transfer (NB: As this is a new measure there is currently no baseline data.)

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

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

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

1. Preventative Services

   - continuing to invest in community based prevention and early intervention activities delivered by voluntary and community organisations that support people with their health and social care needs
   - building on Kirklees' track record as a leader in self-care, including the development of an innovative web based 'hub' which will transform the way self-care information, support and resources are accessible to a wide range of people
   - continuing to support specialist alcohol nurses working in hospitals to reduce alcohol related admissions and repeat presentations for health and care services.

- providing people with long-term conditions who are at risk of hospital admission or needing additional care services with short term support to build their confidence to manage their needs at home.

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

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

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

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

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

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

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

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

In 2016/17 performance was linked to a reduction in non-elective emergency admissions.

Other key performance indicators measured to monitor overall performance were:

Permanent admissions of older people (65 and over) to residential and nursing care homes. Kirklees Performance: 🟢

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services. Kirklees Performance: 🟢

Delayed transfers of care from hospital. Kirklees Performance: 🔴

Dementia diagnosis. Kirklees Performance: 🟢

Sustainability and Transformation Plan (STPs)

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

In response, the NHS and local councils have come together in 44 areas covering all of England to develop proposals and make improvements to health and care. These proposals are place-based and built around the needs of the local population.

The West Yorkshire & Harrogate STP (WY&H) was published in draft in October 2016. http://www.southwestyorkshire.nhs.uk/wp-content/uploads/2016/10/Final-draft-submission-plan.pdf

The priorities of the WY&H plan are highlighted below:

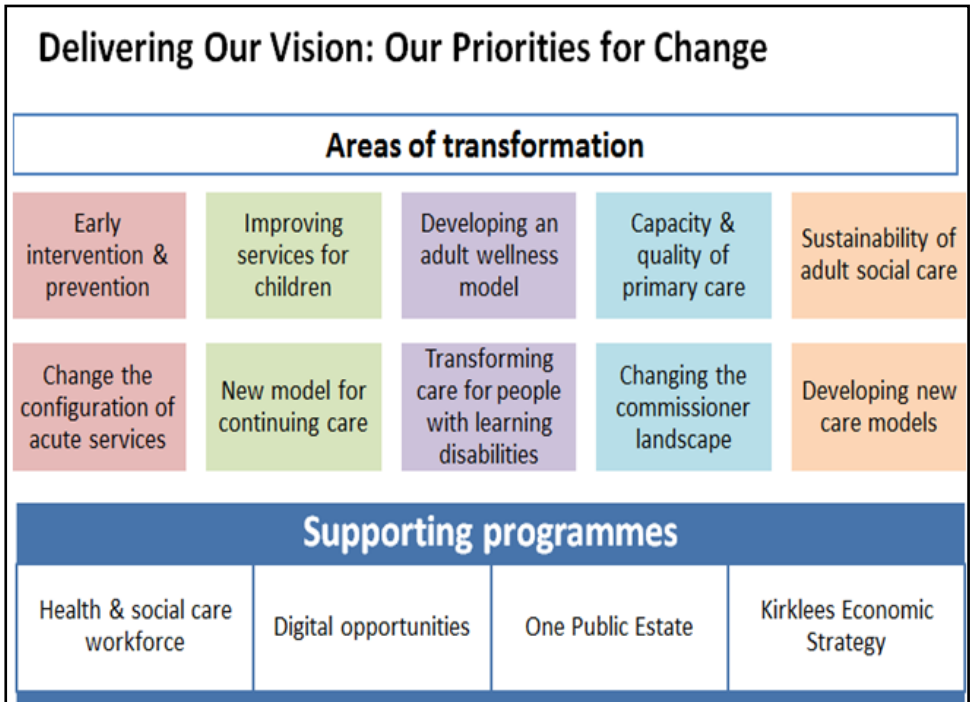
The WY&H STP is underpinned by **6** place based plans.

The Kirklees Health and Wellbeing Plan is the overarching plan signalling the strategic direction for Greater Huddersfield CCG, North Kirklees CCG and Kirklees Council.

The WY&H STP and the local Kirklees Health and Wellbeing Plan must address 3 national challenges: to help set ambitions for local populations;

An approach to optimising health system performance through the simultaneous pursuit of three dimensions: **improving the quality of healthcare; improving the health of the population, and achieving value and financial sustainability.**

The transformation programmes within the Kirklees Health and Wellbeing Plan are:



The Kirklees Health & Well-Being Board have endorsed the direction of travel for the plan:

- There is recognition that the plan is 'live' and will be continually evolving as the workstreams develop and partnership working arrangements become stronger.
- The Plan is due to be endorsed by the CCG's Governing Body in early June 2017.
- Final endorsement by the Health & Well-Being Board is expected at the end of June 2017.

Financial Performance

In the last 12 months the CCG has had some very challenging targets, and has also experienced significant growth in acute activity spend particularly with the local provider.

The CCG had set a savings and efficiency target of £6.5m and set up robust arrangements to engage around the delivery of the schemes. The CCG has achieved over £7m of savings as a result of the processes it has put in place during 2016/17. The CCG had planned to deliver a financial breakeven position before use of a 1% non-recurrent reserve but, due to significant financial challenges, the CCG ended the year £2.5m away from the breakeven plan.

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 Greater Huddersfield CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £3.2m. This additional surplus has been offset against the £2.5m of cost pressures from the current financial year.

After the release of the reserve the CCG has therefore delivered a cumulative surplus of £0.7m. This failure to achieve the reported plan will impact on the CCG's eligibility for Quality Premium payments and the NHS England assurance ratings.

Financial Duties

The CCG has a number of statutory financial duties and targets against which our performance is monitored. Although the CCG has experienced significant financial challenges and although we have not achieved our financial plan we are pleased to be able to report that we have met all of our statutory financial duties. In relation to the public sector payment policy target (non statutory), the CCG has achieved over 95% in 3 of the indicators and 94.5% in the fourth indicator.

The table below shows a summary of the CCG's performance against the statutory financial duties in 2016-17:

Financial Duty	Achieved/Not Achieved	Performance in 2016/17
Achieve operational financial balance	**Achieved**	Delivered surplus of £0.7m
Maintain capital expenditure within Capital Resources	**Achieved**	Utilised capital resource limit of £36k
Manage cash within the CCG's Cash Limit	**Achieved**	Cash balance of £10k

The Performance Report – Sustainability Report

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

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

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

Foreword by Ian Currell, CCG Sustainability Lead

The CCG remains committed to developing sustainable working practices within our role to commission healthcare services for the 247,000 people who live in our area. Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. We acknowledge this responsibility to our patients, local communities, and the environment by working hard to minimise our footprint.

2016/17 has seen the CCG maintain and improve its Good Corporate Citizen score, which reflects the work we have put into achieving our sustainability objectives.

We have been pleased to receive recognition in March 2017 from the Sustainable Development Unit for excellence in sustainability reporting for our 2015/16 Annual Report.

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

Introduction

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

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

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

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

About the CCG

The CCG is a membership organisation of 37 general practices. Its work is led by senior clinicians across the healthcare system and is based on principles of collaboration and partnership between commissioners, providers and the public. The CCG is responsible for commissioning the health care services for the 247,000 people who live in our area (approximately 58% of the Kirklees Local Authority area).

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

What is Sustainable Development?

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

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

The health system is committed to reducing its carbon emissions in line with the UK Climate Change Act. To help the health system achieve this ambition, organisations

are steered by a series of statutory, regulatory and policy requirements as well as high-level guidance[2]:

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

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

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

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

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

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

Vision

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

Goal 1: A healthier environment

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

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

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

Making you a Good Corporate Citizen

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

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

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

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

The CCG's first assessment, carried out in February 2015, resulted in a score of 35%. In April 2016, the CCG undertook a further assessment, and showed an improved score of 46%. The CCG undertook a further assessment in April 2017, and maintained its score with a small improvement of **48%**. Further details are set out within the report outlining the work the CCG has undertaken to improve its score this year.

The following table sets out the scores for each of the 9 areas, demonstrating improvement over the last 2 years:

Area	2014/15 (%)	2015/16 (%)	2016/17 (%)
Corporate Approach	39	83	83
Travel	37	45	52
Procurement	16	18	19
Facilities Management	28	51	49
Workforce	43	52	60
Community Engagement	59	52	55
Buildings	65	69	67
Adaptation	40	49	49
Models of Care	39	56	57

The CCG has previously explained that the Tool only allows 10% of indicators to be scored as Not Applicable, which is challenging for the CCG as a number of sections do not relate to functions that are within our gift. For example, a number of indicators relate to new building projects, which are not the responsibility of the CCG.

Where possible, the CCG interprets the indicators in line with the functions of the CCG, and by doing this manages to keep the number of 'not applicable' indicators within the 10% limit.

The Tool envisages a number of targets:

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

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

Area	Getting Started		Getting There		Excellent	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Corporate Approach	100%	100%	100%	100%	67%	67%
Travel	50 % (11% N/A)	50% (11% N/A)	67% (6% N/A)	72% (11% N/A)	22%	28%
Procurement	50%	56%	22% (6% N/A)	22% (6% N/A)	0%	0%
Facilities Management	89%	89%	67% (17% N/A)	67% (11% N/A)	11% (6% N/A)	11% (6% N/A)
Workforce	78%	78%	67%	67%	28% (6% N/A)	44% (6% N/A)
Community Engagement	72%	72%	61%	61%	39%	44%
Buildings	33% (56% N/A)	33% (56% N/A)	22% (50% N/A)	22% (50% N/A)	0% (61% N/A)	0% (56% N/A)
Adaptation	67% (11% N/A)	67% (11% N/A)	56% (11% N/A)	56% (11% N/A)	28%	28%
Models of Care	89%	89%	72%	78%	33%	33%
TOTAL	**67%** (10% N/A)	**67%** (9% N/A)	**55%** (11% N/A)	**56%** (11% N/A)	**21%** (9% N/A)	**24%** (8% N/A)

Our Performance against our Sustainability Objectives

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

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

In June 2016, the Governing Body approved its Sustainable Development Management Plan (SDMP) for 2016/17 and set a number of objectives, including specific targets to reduce the CCG's carbon footprint. We have detailed our progress against these objectives below:

Area of Focus	SDMP Objective and Plan	Progress
Leadership, Engagement and Development	To develop a new Workforce Strategy, incorporating a Health & Well-Being Strategy.	• The CCG are developing a Workforce Strategy, with seven chapters, including one on health and well-being. Each chapter contains a set of ambitions (looking forward over the next 2-3 years) and an action plan designed to respond to future ways of working and place in the wider system. The first chapters of the Strategy, including the health and well-being chapter, are expected to be completed in Summer 2017.
	To offer all employees the opportunity to participate in the Global Corporate Challenge, with a view to improving the health and well-being of the CCG's workforce.	• All employees were offered the opportunity to participate in the 100 day Global Corporate Challenge between May and September 2016. The majority of staff chose to participate. • The outcomes from the Challenge are very positive in respect of the health and well-being of the CCG's workforce. See further information on page 41.
	To develop the role of Team Sustainability Champions to develop initiatives for office efficiency and a healthy workforce, and to drive the CCG's achievement of Good Corporate Citizen Tool indicators.	• Work continues to introduce Sustainability Champions across all CCG teams. • A Health & Well-Being Task Group has been established with representation from senior management, the Staff Forum and HR. The Group has introduced a number of initiatives to encourage a healthy workforce. See page 41 for further information. • Sustainability is integral to the developing Workforce Strategy, with particular focus on health and well-being of staff.
Carbon Hotspots	To obtain utility usage data from NHS Property Services, establish a reliable baseline, and continue work to reduce usage.	• Following ongoing discussions throughout 2016/17 with NHS Property Services to obtain utilities data, this was received in early May 2017. The information will be used to establish a baseline for 2017/18, which should enable robust reduction targets to be set.

Carbon Hotspots (continued)	To review the SDMP for 2016/17, incorporating the new information relating to our data and carbon footprint, and set a number of carbon reduction goals and specific projects to achieve them.	• The CCG set three key reduction targets for this year:
		  • Utilities – 5%
		  As outlined above, the CCG was unable to obtain utilities data until May 2017. However, regular awareness activities were run by the CCG to encourage staff to be mindful of utility usage.
		  • Business Miles – 5%
		  In 2015/16, the CCG saw a 14% increase in business miles claimed; however, the CCG had also experienced a significant increase in the number of staff following Commissioning Support Unit (CSU) transition. A full breakdown of miles claimed for 2016/17 is not yet available, although the overall value of claims has been provided. This indicates a further significant increase in miles claimed, which is likely to reflect the associated increase in staff numbers.
		  • Paper – 10%
		  Last year (2015/16), the CCG achieved a significant reduction in its paper usage (46%) and set a challenging target to reduce usage by a further 10%. This was particularly challenging due to a significant increase in staff at the end of 2015/16. The CCG has achieved a **5.4% reduction**. The CCG runs regular awareness campaigns, and actively monitors printer usage. Targeted work takes place with high usage individuals.

	To carry out detailed analysis of business miles travelled and claimed during 2015/16 and 2016/17 to establish reliable baseline and improve accuracy of reporting.	• In 2015/16, the CCG saw a 14% increase in business miles claimed; however, the CCG had also experienced a significant increase in the number of staff following CSU transition. • For 2016/17, the CCG set itself a 5% reduction target.

		• Detailed analysis has commenced and will continue in coming months, to establish a more reliable baseline and improve accuracy of reporting. • The CCG has carried out its first staff travel survey.
Carbon Hotspots (continued)	To identify opportunities to introduce paperless systems.	• The CCG has been working to identify systems that could be paperless. • In July 2016, the CCG moved to a paperless procedure for mileage and expenses claims. • The CCG has also been developing a new paperless declaration of interest system for use by staff and the CCG's membership. This will be introduced early in 2017/18.
Commissioning and Procurement	To develop an action plan to identify how to achieve the Getting Started and Getting There 'Procurement' indicators on the GCC Tool.	• Initial discussions have taken place at the Kirklees Sustainability Partnership. • Work to develop an action plan within the CCG has been deferred until the first half of 2017/18.
Sustainable Clinical and Care Models	To undertake consultation on proposed changes to hospital services to understand views about the way in which Emergency and Acute Care, Urgent Care, Maternity Care, Paediatric Care, Planned Care and Community Health Services are provided in the future.	• A period of consultation commenced on 15 March 2016 and lasted for 14 weeks. This included three public meetings, 17 information sessions, and at least 36 other meetings.
	To make an informed decision on progressing the future shape of hospital services ensuring that these are high quality, safe, sustainable and affordable and result in the best possible outcome and experience for patients, as well as on which services should be provided in the community closer to where people live.	• In August 2016, both Governing Bodies entered into a period of deliberation on the findings from the consultation. • On 20 October 2016, the Governing Body determined that the findings from the consultation and the subsequent deliberation provided sufficient grounds to proceed to explore implementation in the Full Business Case.

Healthy, Sustainable & Resilient Communities	To fully participate in the Kirklees Sustainability Partnership, taking opportunities to share learning with our colleagues across the health and social care sector and be an advocate for sustainability.	• The CCG continues to play a key role in the Kirklees Sustainability Partnership – where commissioners and providers from Greater Huddersfield CCG, North Kirklees CCG, Kirklees Council, Calderdale & Huddersfield NHS Foundation Trust, Mid Yorkshire Hospitals Trust, and Locala are working in partnership to achieve a number of sustainability goals. • The Partnership helps support organisations with their individual Sustainability Plans, but also recognises the benefits of partnership working, identifying interdependencies and mutual support. • All partners have shared their Good Corporate Citizen tool (or equivalent) scores and the Partnership holds quarterly focussed sessions on particular issues.
Innovation, Technology, Research & Development	To introduce video-conferencing technology.	• The CCG has introduced video conferencing technology; first meetings in December 2016. • Joint meetings between the CCG and neighbouring CCGs are regularly taking place via video conferencing. Other opportunities are being identified and have included the CCG's Assurance Meeting with NHS England. A number of teams, with staff shared across bases, are utilising the technology for team meetings.
	To identify opportunities to be innovative and use technology to introduce paperless systems.	• The CCG has been working to identify systems that could be paperless. • In July 2016, the CCG moved to a paperless procedure for mileage and expenses claims. • The CCG has also been developing a new paperless declaration of interest system for use by staff and the CCG's membership. To be introduced early in 2017/18.
Creating Social Value	As set out above	
Integrated Metrics	As set out above	

During 2016/17, we have…

…received **recognition for having excellent sustainability reporting** as part of our 2015/16 annual report. The CCG has received a certificate for 'Excellence in Sustainability Reporting' awarded by the Sustainable Development Unit, NHS Improvement and the Health Finance Managers Association. High quality reporting on sustainability is recognised as a key way organisations can show their commitment to embedding environmental, social and financial sustainability.

…established a **Health & Well-Being Task Group** to take forward work across the health and well-being spectrum. The Task Group draws together multiple perspectives (senior managers, Staff Forum, HR, and learning and development) to oversee plans for sustaining staff well-being; supporting access to learning and development opportunities; proposing and developing topics for staff briefings and workshops; and coordinating organisation wide events focussing on staff health and well-being.

…worked with our landlord, NHS Property Services, to introduce **healthier choices** in the staff vending machines.

…launched **video conferencing** with meetings now regularly taking place between the CCG and other organisations. Other opportunities have been identified, including the CCG's quarterly assurance meeting with NHS England which took place via video conference for the first time in 2017.

…celebrated **CCG Sustainability Week** from 20-24 March 2017. We know that sustainability is relevant to everything we do as a CCG – whether it be the way we commission and procure services, how we engage with our local communities, how we travel to work and to meetings, or about the health and well-being of us all. During the week, we took the opportunity to raise awareness about what sustainability means both to us as individuals and to the CCG. It was also an opportunity to set ourselves goals for 2017/18. Each day we focussed on a different aspect of sustainability – utility usage; active travel; recycling; and using technology. Other activities during the week included lunchtime walks, sustainability related quizzes and competitions, and staff workshops focusing on personal resilience.

…taken part in a **Global Corporate Challenge**. The challenge involved staff signing up in teams of seven to take on a 100 day journey designed to improve both physical and psychological health. Key outcomes included:

- 70% of participants exceeding 10k steps a day, compared with 15% prior to starting.
- 33% of participants meeting nutritional guidelines at the end of 100 days compared with 15% prior to starting.
- A total reported weight loss of 8st 13.5lbs.
- 74% of participants said they felt less stressed at the end of 100 days.
- 62% of participants said they were concentrating better/feeling more productive at the end of 100 days

The CCG will be undertaking a further challenge during 2017.

Our Carbon Footprint

Utility Usage

Following ongoing discussions throughout 2016/17 with NHS Property Services to obtain utilities data, this was received in early May 2017. This follows a prolonged period when the CCG was unable to access any information on utility usage.

As a tenant in a multi-occupier building, which has a significant amount of vacant space, identifying the CCG's utility usage is particularly challenging. Calculations for utility usage in 2013/14 and 2014/15 have been based on an estimate that the CCG is responsible for 30% of the building's utility usage. Following changes to occupation of the building since 2015, this is no longer likely to be an accurate calculation. As information was only received in May 2017, the CCG will use this to establish a baseline for 2017/18, which should enable robust reduction targets to be set going forward.

Business Miles – target 5% reduction

A full breakdown of miles claimed for 2016/17 is not yet available, although the overall value of claims has been provided. This indicates a further significant increase in miles claimed, which is likely to reflect the associated increase in staff numbers. The CCG continues to work closely with our payroll provider to identify the number of business miles claimed by staff during 2016/17. Information relating to public transport is not currently extractable. We will continue to investigate how this could be monitored.

The CCG has commenced more detailed analysis of business miles travelled and claimed during 2016/17 and will continue with this work, in order to improve the accuracy of reporting.

Paper Usage – target 10% reduction; achievement 5.4% reduction

The CCG set itself an ambitious 10% reduction target for paper, following a significant reduction (46%) during 2015/16. This was made more challenging due to a significant increase in staff at the end of 2015/16. The CCG runs regular awareness campaigns, and actively monitors printer usage. Targeted work takes place with high usage individuals.

Waste

Responsibility for waste collection lies with NHS Property Services and until May 2017, the CCG had been unable to obtain any data for general waste collection since April 2015. Data prior to 2015 was based on a 30% estimate of the total building collection, however following changes to occupation of the building since 2015, this is no longer likely to be an accurate calculation. As information was only received in May 2017, the CCG will use this to establish a baseline for 2017/18, which should enable robust reduction targets to be set going forward. During 2016/17, responsibility for recycling waste collection also moved to NHS Property Services, and the CCG has been unable to obtain any data for 2016/17.

Carbon Footprint Table

Resource	Quantity			CO^2 Emissions (tonnes)			Cost (£)		
	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17	2014/15	2015/16	2016/17
Gas (kWh)	47,413	*	184,606 (to Feb 2017)^	9.9	*	38.7 (to Feb 2017)^	£1,898	*	£4,507 (to Feb 2017)^
Electricity (kWh)	106,193	*	21,361^	65.8	*	13.2^	£14,814	*	£27,621^
Business Miles Travelled (miles)	46,870	53,261	**	17	20	**	£27,737	£29,087	£39,918
Public Transport Miles	-	-	-	-	-	-	-	-	-
General Waste (tonnes²)	5.1	*	32^	1.2	*	7.8^	£609	*	£4,068^
Recycling (including confidential waste) (tonnes²)	1.9	*	*	0.04	*	*	£1,004	*	*
Water (m^3)	917	*	2,842^	1	*	3^	£3,160	*	£10,675^

* Please note utility usage and waste figures not available from NHS Property Services.
** Please note business miles travelled not currently available from the CCG's payroll provider.
^ Represents 100% of Broad Lea House usage; not solely CCG usage.

The Performance Report – Statutory Duties

The CCG is required to comply with a number of statutory duties. The CCG monitors compliance with these throughout the year and we have sought to demonstrate this throughout the Annual Report. Whilst we have complied with all of our statutory duties, the Health & Social Care Act 2012 (as amended) includes a number of legislative requirements for CCGs in respect of the information we must include in our Annual Report. In this section, we have summarised our activities in a number of areas:

Ensuring the continuous improvement in quality

(Section 14R, NHS Act 2006 (as amended))

Ensuring patient safety and improving quality is core to our business. We work hard to maintain strong relationships with our providers and this enables us to take forward the learning from reviews from the National Quality Board such as *Shared Commitment to Quality*, a new framework that will promote improved quality criteria across all national health organisations, and the recent findings of the Care Quality Commission report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*.

Our focus on reducing harm, improving effectiveness and experience includes:

- Local CQUIN (Commissioning for Quality and Innovation) targets
- Supporting incident reporting and sharing lessons learned particularly across the whole system
- Members of the national patient safety initiative Sign up to Safety and participation in campaigns such as National Kitchen Table Week
- Embedding the use of quality impact assessments in all commissioning decisions to ensure we understand and mitigate any impacts on quality
- Using patient experience data collected through our patient story process and Patient Experience Group, to help inform commissioning decisions and make improvements in partnership with our providers
- Developing a programme of quality improvement training with our partners Yorkshire and Humber Improvement Academy

Reducing Inequalities

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

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

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

Consultation and Work with the Health & Wellbeing Board

(Health & Social Care Act 2012 (as amended))

The CCG continues to be an active member of our local Health & Wellbeing Board. The work of the Board, and delivery of the Joint Health and Wellbeing Strategy, is reflected throughout the Annual Report and key areas of discussion have included:

- West Yorkshire & Harrogate Sustainability & Transformation Plan
- Integration of Health and Social Care in Kirklees
- Right Care, Right Time, Right Place
- Primary Care Strategy
- Care Home Strategy
- Transforming Care Partnership Plan
- Kirklees Joint Strategic Assessment
- Healthy Child Programme
- Community Wellness Model of Health Improvement for Kirklees
- CAMHS Transformation Plan

Throughout 2016/17, the CCG has played a key role in developing the Kirklees Health and Wellbeing Plan 2017-2021, which is closely connected with the Kirklees Joint Health and Wellbeing Strategy.

During the latter part of 2016/17, the CCG has participated in a piloting of a new system wide health and social care peer challenge by the Local Government Association.

Public Involvement and Consultation

(Section 14Z2, Health & Social Care Act 2012 (as amended))

The CCG aims to involve people as early as possible in the development of services and to have a voice in commissioning decisions. As part of our duty to involve local people we have a published strategy which sets out our approach to engagement and patient experience. As part of our approach we want to involve those who will be most affected including local people who represent the voice of our most vulnerable and protected groups. By ensuring local people have a voice and are involved in any service change, plan or proposal, we can ensure services meet the needs of the people who use them now and in the future.

Our aim is to involve local people through a range of methods either individually or through a range of partners such as the voluntary and community sector, patient reference groups and organisations such as Healthwatch. This year we have involved people in a number of service areas and projects. A number of examples from this year are:

- **Right Care, Right Time, Right Place** – a formal consultation for hospital and community services which started in March 2016 until June 2016. The findings from the consultation were used to determine the future of hospital and community services.
- **Care Closer to Home** – engagement on podiatry services led by Locala to determine how services can be provided in the future.
- **Talk Health** - a programme of campaigns and conversations to ensure the CCG can manage services within existing finances.
- **Healthy Child Programme** – engagement with young people, schools, healthcare providers, parents and families on the future of healthcare services for children and young people led by the Local Authority in partnership with the CCG.
- **Whitehouse Centre General Practice** – engagement with patients, staff and key stakeholders on the services received at the Whitehouse practice.

Case Study – Right Care, Right Time, Right Place

A formal consultation on the future of hospital and community services started in March 2016 and ended in June 2016. The consultation included proposals for both hospital and community services in both Calderdale and Greater Huddersfield. The consultation lasted 14 weeks and included a range of events and activities to gather the views of local people. The consultation process received independent assurance from the Consultation Institute and met the Institute's best practice standards.

These activities included:

- 3 public meetings
- 17 information sessions
- A survey included in 'Calderdale Talkback'
- Targeted work with Children and Young People
- Conversations with a range of staff and partner organisations
- Conversations through local community and voluntary sector organisations

Over 7,500 people replied to the survey and in addition we received over 500 phone calls, letters, documents, texts and emails and 8 petitions. The feedback from the consultation was independently analysed and a report of findings was produced. The report provided feedback on each question asked but also highlighted six general key themes. The key themes were:

1. **Travel and Transport:** People raised concern about the impact of increased travel times to services on patient safety, Elland Bypass congestion, access to and cost of public transport and car parking at Calderdale Royal Hospital.
2. **Clinical safety and capacity:** People asked if the proposed model for urgent and emergency care would work and if it would impact on GPs, the ambulance service and Calderdale Royal Hospital or other hospitals outside the area.
3. **Rationale for change:** people wanted to understand further the proposed model and how it was clinically driven. Also if staff supported the proposals and how any changes to hospitals could be funded.
4. **The consultation process:** including why only one option was consulted upon.
5. **Understanding the proposal:** people wanted more information on how changes to the current system would work in practice particularly urgent and emergency care services.
6. **The need for change:** A large number of respondents acknowledged the need for change and offered alternative options for sites, travel and travel and transport.

The findings from the consultation were deliberated by both NHS Calderdale and NHS Greater Huddersfield CCG; in addition there were responses from organisations such as Healthwatch and the Local Authority to consider. More work to involve local people in the development and design of a future model will take place as the CCGs move to the development of a full business case.

Case Study – Whitehouse Centre Engagement

The CCG is committed to improving the healthcare available to all the people living across the district. As part of this continued work, the CCG embarked on the re-procurement of the Whitehouse Centre in Huddersfield last summer. The Whitehouse Centre is a service established for patients that are homeless or living in emergency accommodation, and for patients that are asylum seekers.

The CCG's Engagement Team engaged with the patients and key stakeholders over a six week period, from 9 May to 20 June 2016. Considering the profile of the service users, it was proposed that we use a combination of methods and approaches which included distribution of questionnaire and focus group work.

The recommended engagement approach was to use our local community assets 'Community Voices' to deliver conversations with targeted service users from a variety of local areas, protected groups and communities. The groups involved with the conversations were:

- **DASH** - A charity with the specific purpose of assisting destitute refugees and asylum seekers and also new refugees who are homeless.
- **The Basement Recovery Project** - Offers support and inspiration to those people who are involved with alcohol and / or substance misuse.
- **Volunteers Together** - Offers asylum and refugee drop-ins with practical advice and support, signposting and referrals.
- **Huddersfield Mission** – A café with advice and support on alcohol issues, drug problems, rough sleepers, homelessness, tenancy problems, benefits and debt advice.

In parallel, Public Health also conducted an evaluation of Whitehouse Centre activity data and two facilitated sessions were held in February and May engaging key stakeholders.

The CCG received over 250 responses to the engagement from a range of patients and the community representing different organisations of interest across the local area. This represents a good sample size considering the profile of the service users (17% of the practice size, 1,480 patients).

The findings from the engagement have highlighted these key themes:

1. According to patients, the service is of a high quality and they value the Whitehouse Practice and the services. Patients also explained how they are extremely grateful for the interpreting service.
2. Patients were complimentary about the practice staff and the service.
3. The practice is conveniently located.
4. Emotional wellbeing and having appropriate support is very important to this cohort of patients.
5. Patients reported that they found it difficult to book appointments.
6. The mental health support service was also well used and seen as an important support network for the client group.
7. Travel costs such as bus fares were cited as one of the main barriers to attending the practice.
8. Many patients thought that the waiting room was too small and it needed more staff.
9. Some patients were not aware of this service: The service could not be used as much as patients may like because they are not aware of the provision
10. The practice staff have a clear understanding of the patient group they serve despite many patients being transient or having very complex health needs. However, more could be done to ensure staff can inform and communicate more clearly with those patients who are homeless, a refugee or asylum seeker.

The data was used to inform the equality impact assessment on the procurement, and the information gathered informed the future service specification.

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report 2016/17

The Accountability Report

Carol McKenna
Accountable Officer

25 May 2017

The Accountability Report

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

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

Corporate Governance Report – Members' Report

Our Member Practices

NHS Greater Huddersfield CCG is a membership organisation that consists of 37 GP practices:

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

Our Chair and Accountable Officer

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

Our Governing Body

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

Required Composition	Persons in Post
8 representatives of member practices, one of whom shall be appointed chair.	Dr Steve Ollerton (Chair) Dr Razwan Ali (from 1 October 2016) Dr Dil Ashraf (from 1 September 2016) Dr Chris Beith Jenny Cullearn (from 1 September 2016) Dr Ramesh Edara (until 31 August 2016) Dr Jane Ford Dr Anuj Handa (until 30 September 2016) Dr David Hughes Dr Matthew Kaye
2 lay members, one of whom shall be appointed deputy chair: (i) One to lead on audit, remuneration and	(i) David Longstaff

conflict of interest matters; (ii) One to lead on patient and public participation matters.	(ii) Priscilla McGuire (Deputy Chair)
1 registered nurse	Angela Monaghan
1 secondary care specialist doctor	Irving Cobden
The accountable officer	Carol McKenna
The chief finance officer	Julie Lawreniuk (until 28 April 2016) Lesley Stokey (29 April-30 September 2016) Ian Currell (from 1 October 2016)
The senior manager with responsibility for quality	Penny Woodhead

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

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

During 2017/18 the Governing Body will be joined by a third Lay Member, to be appointed without specific portfolio, but with an intention to focus on CCG strategic priorities. This will support the management of conflicts of interest, in line with national guidance which recommends the appointment of three Lay Members.

Our Committees

The Governing Body has appointed the following Committees:

- Audit Committee
- Finance & Performance Committee
- Primary Care Commissioning Committee
- Quality & Safety Committee
- Recovery Committee
- Remuneration Committee

For further information on all our Committees, including their terms of reference and membership please see the Governance Statement (page 55).

Register of Interests

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

Disclosure of Personal Data Related Incidents

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

Statement as to Disclosure to Auditors

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

- So far as the member is aware, that there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and
- That 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 Greater Huddersfield 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.

Corporate Governance Report – 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 the Chief Officer to be the Accountable Officer of NHS Greater Huddersfield 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,
- For keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction),
- 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 Section14R 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; and,
- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out 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.

Carol McKenna
Accountable Officer

25 May 2017

Corporate Governance Report – Governance Statement

Introduction and context

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

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

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

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.

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.

The CCG Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

> ***'The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.'***

Key Governance Features of the CCG's Constitution

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

patients and the public remain central to our goals.

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

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

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

Governing Body

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

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

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

The Governing Body is also supported by a Lay Advisor focusing on Financial Management and Primary Care Commissioning.

During 2017/18, the CCG will appoint a third lay member to the Governing Body to strengthen conflicts of interest management.

Committees of the Governing Body

In 2016/17, the Governing Body had six committees to support its work. The full terms of reference of these committees are available at www.greaterhuddersfieldccg.nhs.uk.

Membership and Attendance Records

Details of the membership of the Governing Body and its Committees are set out on page 79 – this also includes each member's attendance record over the past year.

The Governing Body's Committees

Audit Committee

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

The Committee has identified the following highlights from their work:

- Much of the Committee's work underpins the work of the rest of the CCG, enabling its governance arrangements to work in a more effective and safer manner. Risk Register and Board Assurance Framework reporting has continued to improve. The improved quality and consistency of presentation has enabled the Committee to look in more depth at the assurances given.
- The overviews of the risks and controls concerning Financial Management, Quality & Safety, and Contracting & Procurement continue to play a major part in the Committee's understanding of the CCG's operations.
- The statutory financial targets set by the CCG continue to be met.
- The CCG achieved 100% compliance with the Information Governance Toolkit.

Finance & Performance Committee

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

The Committee has identified the following highlights from their work:

- Rigorous discussions on the CCG's financial position each month, with the Committee developing a strong understanding of the current position.
- Strong focus on the CCG's recovery plan and QIPP targets.
- Identification of key finance and performance risks and opportunities to address these.

Quality & Safety Committee

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

The Committee has identified the following highlights from their work:

- The development of a robust process for assessing quality and equality impacts of schemes included in the CCG recovery programme and ensuring that the appropriate levels of engagement are undertaken prior to ratification of the schemes.

- A marked increase in the number of member practices in the CCG participating in research activity compared to last year.
- The implementation of the NHS England Quality Assurance process within primary care. This process has been useful in ensuring a standard approach to specific practices where concerns have been identified and has been instrumental in ratifying practice quality improvement plans.
- The Quality Issues Alert System was developed in 2014/15 and provides GP practices with an opportunity to tell the CCG about quality issues they are hearing from patients or experiencing themselves. During 2016/17 there has seen a step change in the number of issues reported, and all practices in the CCG are now reporting quality concerns via this mechanism. This has allowed the Committee to analyse the data for themes and trends and shapes the discussions with providers in order to improve systems and processes.
- The Quality and Safety dashboard has been revised and now gives a clear approach to the levels of surveillance for providers and clearly identifies issues for escalation. This allows the committee direct sight on the quality performance of providers and the ability to monitor progress in areas requiring improvement.
- The development of a Patient Experience Group. Established across Calderdale, Greater Huddersfield, North Kirklees and Wakefield the group has the remit of sharing good practice to improve patient experience across the main providers.
- Marked assurance to NHS England of CCG Safeguarding Arrangements. Following completion and submission of an extensive self-assessment tool requested by NHS England, both Designated Nurses (Safeguarding Adults and Safeguarding Children) and the Head of Quality & Safety met with NHS England representatives to review the completed document and for the evidence to be scrutinised. Written feedback was provided by NHS England in August 2016 and detailed that the CCG team were able to demonstrate compliance with virtually all the requirements. Out of the 28 sections there were just four areas which required further work. Where possible this has been completed.

Remuneration Committee

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

The Committee has identified the following highlights from their work:

- The approval of a number of key HR policies including: Flexible Working Policy; Annual Leave & Special Leave Policy; Disciplinary Policy; Grievance Policy; Alcohol & Substance Misuse Policy; Employment Break Policy; Retirement Policy; and Trade Union Recognition Policy.
- The recruitment of a new Chief Finance Officer for the organisation.
- The development of an Off Payroll Policy and consideration of IR35 implications for the CCG.
- A remuneration review for those outside of the Agenda for Change framework.

Primary Care Commissioning Committee

From 1 April 2016, the CCG established a committee for the purpose of commissioning primary medical services for the people of the Greater Huddersfield area, under full delegation from NHS England. The role of the committee is to carry out the functions relating to the commissioning of primary medical services under Section 83 of the NHS Act. This does not include individual GP performance management, as this is carried out by NHS England.

The Committee has identified the following highlights from their work:

- The establishment of a new committee and building knowledge and understanding of a new area of work.
- Enabling clinical input whilst effectively managing conflicts of interest.
- Clearer local ownership of primary care issues, with robust discussions on a number of matters affecting primary care.

Recovery Committee

From September 2016, the Governing Body established a committee to drive forward delivery of the CCG's Recovery Plan with rigour and pace. The Committee has met a number of times during 2016/17 and made a number of decisions including those within the Talk Health Kirklees consultation.

Governing Body – Assessment of Performance and Effectiveness

The Governing Body has assessed itself against the Good Governance Institute/NHS England maturity matrix. This is designed to help CCGs self-assess that they are achieving the expected desirable outcomes of good governance practice.

Key Elements	Progress Level – March 2017
Clarity of Purpose	**Results – initial achievements evident** Most of membership able to articulate vision and purpose. Decisions consistent with vision. Objectives, strategy and business plans are consistent with mission and vision.
Leadership and Strategic Direction	**Results – initial achievements evident** The membership and key stakeholders agree that the CCG leadership are working towards achieving the strategic goals. Clinicians new to leadership roles are involved in CCG business.
Effectiveness of relationships	**Maturity – results consistently achieved** Local providers, partner organisations, and other stakeholders agree that the CCG is materially influencing their plans and performance. CCG contribution valued by partners.
Membership Support	**Early Progress – early progress in development** Members generally engaged in CCG business and participate at various levels in decision-making. Members comply with decisions and policies agreed by the CCG.
Public and Community Engagement	**Maturity – results consistently achieved** Leaders in the CCG value community input as a source of insight that helps make better decisions. CCG is able to demonstrate that public/community engagement has led to change. Engagement methods in line with sound social science practice.
Quality and Safety Structures and	**Results – initial achievements evident** CCG decisions and operational plans can be linked to formal CCG structures and systems to improve care standards in line with the evidence base. New

Systems	responsibilities such as collaborative commissioning have been formalised. Systems are in place that enable the CCG to deliver its duty of care, including safeguarding.
Focus on Outcomes	**Results – initial achievements evident** Identifiable changes in referral patterns towards operational goals. Early signs of desired process changes taking place. Patient and carer experience positive outcomes.
Better Decision-making	**Results – initial achievements evident** There is a consensus amongst the membership and stakeholders that CCG decisions have been thoughtfully made and are fair. Evidence has been used when decisions are made. Conflict of interest issues routinely recognised and managed.
Control Systems	**Maturity – results consistently achieved** Members consider the CCG to be a well-governed organisation, and value the governance mechanisms that are in place, such as the election processes to the governing body and approaches to resource distribution. The CCG's audit committee are confident that the CCG's control and assurance systems are fit for purpose.
Legal and Regulator Compliance	**Maturity – results consistently achieved** Local providers, partner organisations and other stakeholders understand the CCG's legal duties and would agree that these are being discharged.
Organisational Effectiveness	**Maturity – results consistently achieved** Internal stakeholders are confident of organisational effectiveness. External reviews of governance/organisational effectiveness.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. 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. These are referred to throughout the Annual Report and Governance Statement as follows:

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

The CCG's Audit Committee undertakes regular monitoring of the CCG's compliance with the provisions of the Code, identifying where action is needed, and will continue to do so in 2017/18.

Discharge of Statutory Functions

In light of recommendations of the 1983 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 legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead senior manager. Senior managers have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk management arrangements and effectiveness

As a publicly accountable organisation, the CCG needs to take many informed, transparent and complex decisions and manage the risks associated with these decisions. The CCG therefore needs to ensure that it has a sound system of internal control working within the organisation.

The CCG Risk Management Framework

The CCG has an Integrated Risk Management Framework, which outlines the effective governance arrangements in place to manage all types of risks faced by the organisation. It describes:

- The CCG's approach to managing risk and risk management processes.
- The CCG's risk management objectives.
- The CCG's organisational and individual accountability for risk management.

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

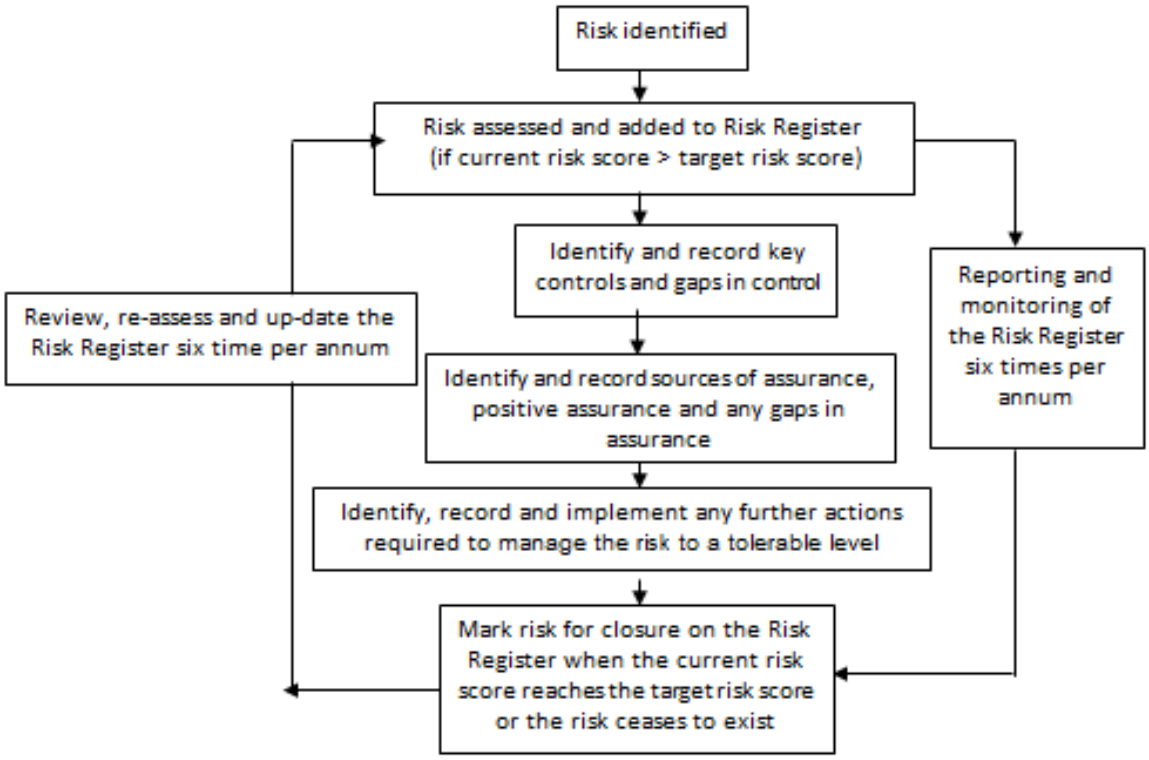
The Framework sets out five strategic objectives for risk management:

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

   The CCG's risk management process draws on the AS/NZ ISO 31000:2009 international risk management standard. This describes the risk management process as:

   - Establishing the risk context
   - Risk assessment
   - Treating the risk
   - Reviewing and monitoring risk
   - Risk management and partner organisations

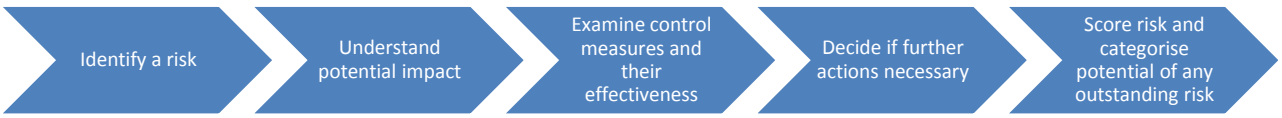
   The risk assessment, management and reporting process is illustrated in the chart below:



Risk can only be managed if it is identified, and triangulation of soft and hard information from different sources gives assurance that all significant risks have been captured. The key sources of information used to check completeness of risk capture are:

- Performance indicators reporting variance from plan within commissioning; performance contracts and their reports;
- The results of planned reviews of compliance within statutory and regulatory requirements;
- Routine review of serious incidents, incident reports and complaints to identify emerging risks such as themes or specific concerns which can be escalated to the appropriate risk registers;
- Utilisation of intelligence through partner networks and from stakeholders to encourage the sharing of information to identify potential risks;
- Ensuring contact with regional and national professional associations that provide early warning on serious or major adverse events;
- Risk review and discussion through operational groups and formal meetings – Senior Management Team, Governing Body, Quality and Safety Committee, Finance and Performance Committee, and Audit Committee, which highlights problems and issues which should be reflected in the risk register;
- Risk identification is also supported through review processes using the live risk register including team and contract review meetings.

A structured process is used for risk assessment:



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

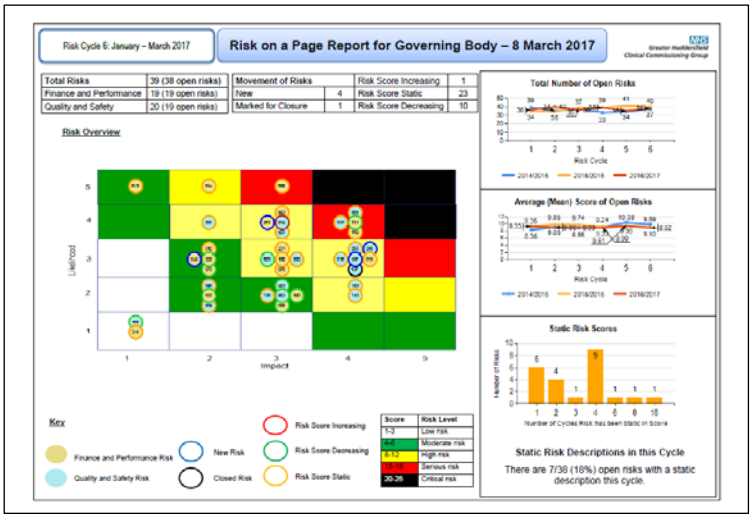
Consequence	Likelihood				
	Rare 1	Unlikely 2	Possible 3	Likely 4	Almost Certain 5
Insignificant 1	1	2	3	4	5
Minor 2	2	4	6	8	10
Moderate 3	3	6	9	12	15
Major 4	4	8	12	16	20
Catastrophic 5	5	10	15	20	25

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

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

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

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



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

The Risk Register identifies and manages performance based risks that may rise and fall within relatively short term periods – in essence, our operational risks. The Assurance Framework is a Governing Body level assessment of the organisation's objectives and the risks that may prevent or hinder the objectives being achieved. It includes an assessment of the controls that are in place to manage the identified risks.

The sources of assurance received by the Governing Body are analysed and documented in the framework. Any gaps in assurance or controls are identified and suitable action plans developed to address them.

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

In March 2017, Internal Audit undertook a review, which received Significant Assurance, to ensure that:

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

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

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

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

  We have the opportunity to gather valuable learning information from a range of systems and activities, and we have processes in place to capture this learning. This includes:
  - Reviewing the risk register for closed risks to assess whether there are any issues which need to be incorporated in processes to minimise occurrence in future.
  - Investigating incidents, complaints and claims using root cause analysis to identify underlying issues which require improvements or interventions to reduce the chance of reoccurrence.
  - Triangulation of intelligence on complaints, incidents and claims with soft intelligence and feedback from stakeholders.
  - Regular CCG incident reporting to the Audit Committee and provider serious incident reporting to the Quality & Safety Committee.

- **Learning from others and using best practice**
  We collate information from a range of data sources to identify and implement best practice, including:
  - Feedback from external reviews of organisational systems – for example, internal audit, Care Quality Commission reviews, Ofsted, and the Ombudsman.

- Using local and national professional networks to identify best practice and benefit from the experience of others.
- Research and guidance published by professional bodies.
- Recommendations from external investigations and formal inquiries.

3. Ensure Clear Accountability for Risk Management

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

4. Ensure Statutory and Regulatory Compliance

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

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

5. Manage Partnership Risks

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

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

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

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

Risk Assessment

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

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

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

Risks to Governance, Risk Management and Internal Control

As set out above, the CCG's corporate risk register details all risks relating to governance, risk management and internal control during the course of the year or after year end. We have identified below those risks to governance, risk management and internal control deemed to be major (ie scoring 15 or above) up to 24 May 2017:

Risk	How CCG has acted to manage the risk	How outcomes will be assessed
There is a risk that Children's CHC expenditure will continue to increase in 2016/17 resulting in an inability to meet financial targets due to a number of financial challenges. (Added April 2016; risk score reduced from September 2016 and no longer high level risk)	• All cases have had reviews. • CHC nurse attends local authority resource panel to prevent cases escalating. • Children's Continuing Care Policy drafted.	• Weekly reports from finance to the budget holder to identify changes.
There is a risk that the CCG will fail to deliver the 2016 -17 planned financial break-even position. This is due to the potential for a number of financial pressures including acute contract overspends, continuing healthcare overspends, prescribing overspends and failure to deliver the QIPP cash releasing savings, which could need to be mitigated to ensure delivery. This could result in the CCG entering into a deficit position which would result in the CCG being placed into an NHS England formal recovery programme. (Added May 2016)	• Financial plan, approved by Governing Body • Quality Innovation Productivity and Prevention (QIPP) plan developed and managed through internal recovery programme. • Recovery Plan submitted to NHS England. • Recovery Committee established. • Monthly budget monitoring process to review expenditure against budgets. • Monthly reports to Finance & Performance Committee and Governing Body. • Utilisation of contingency budget.	• Monthly reports to Finance & Performance Committee and Governing Body. • Reports to NHS England.

Risk	How CCG has acted to manage the risk	How outcomes will be assessed
There is a risk that the main acute contract with Calderdale and Huddersfield NHS Foundation Trust (CHFT) over-trades significantly by the end of the year due to increased levels of A&E attendances and emergency admissions and increased demand in terms of GP referrals, outpatient and diagnostic activity with the potential to convert into daycase or elective inpatient activity. This could have a detrimental effect on the CCG financial position. The forecast outturn based on an early view of Month 2 is £3.6m (assuming that higher levels of critical care activity do not continue). (Added June 2016)	• Contract position discussed at monthly Contract Management Group and bi-monthly Partnership Board. • Transformation Group meets monthly. • System pressures discussed at monthly A&E Delivery Board. • Commissioning for QIPP teams focus on supporting the delivery of secondary care QIPP and managing demand. • Analysis undertaken in relation to key pressure areas and a number of counting and coding issues have been identified. • Hypotheses action plan developed and shared across the organisation.	• Monthly contract position reported to Finance & Performance Committee. • 2016/17 year end agreement reached to include an adjustment for counting and coding issues identified in-year.
There is a risk that patient safety, experience and the quality of care delivered could be adversely affected due to Local Care Direct's (LCD) capacity to meet demand and achieve expected national quality requirements (NQRs). (Added June 2016)	• OPEL protocol to manage increasing demand and escalation embedded within YAS and LCD. • Failed 1 hour appointments audited to monitor impact on patient care/outcome. • Queue management protocols in place; queue management role now in place on all shifts. • On day management of rotafill, real time management of staff. • Supporting measures including introduction of new telephony software with aim of supporting improved real time monitoring of LCD contact centre activity and productivity. • PURM scheme implemented for patients to access urgent repeat medication via NHS111 and pharmacies.	• Commissioner assurance visits • Low level of serious incidents

Risk	How CCG has acted to manage the risk	How outcomes will be assessed
There is a risk that a comprehensive understanding of increases in demand and the trading position are not fully supported by data analysis due to a lack of capacity, knowledge, experience and skills in the BI service which could result in a lack of understanding of intelligence to support manage pressures on key acute and independent sector contracts and to fully support service development and improvement initiatives. In addition, issues have arisen in relation to the demand planning process. Key pieces of work have not been completed within the required timescales resulting in a lack of understanding of the impact of HRG4+ (the 17/18 and 18/19 national tariff impact) and a lack of robust contract plans being available to support contract negotiations. (Added July 2016; risk score reduced from April 2017 and no longer high level risk)	• Monthly contract meeting and a monthly service review meeting in place with the BI service provider Embed. • Four workstreams set up to develop and review systems and processes in time for the next planning round. • Internal (CCG) recruitment into BI posts able to better support service development and improvement initiatives.	• Monthly contract meeting

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

- That we will be unable to commission safe, high quality services for our population due to the local health and social care system being unable to recruit and retain the workforce required.
- That there will be insufficient staff for effective General Practice – GPs, nurses and practice managers – due to the inability to recruit resulting in the quality of care reducing.
- That providers of commissioned NHS funded services are not subject to the requirements set out within the NHS Standard Contract due to a contract not being in place leading to loss of leverage to ensure appropriate provider workforce is in place.
- Failure to maintain and improve the quality and safety of services due to ineffective assurance resulting in harm to patients.
- That commissioning arrangements for safeguarding do not ensure providers are effectively discharging their duties due to ineffective safeguarding arrangements with partners, resulting in harm to children and adults.

- That the spending on healthcare across the health economy is not delivering the full benefit for the resource deployed resulting in patients not getting the full of the funding spent in Greater Huddersfield.
- That we are unable to secure active participation particularly from Member Practices resulting in the CCG's ability to deliver its priorities.
- That we are unable to secure effective partnerships to deliver shared priorities and service change.
- That the CCG will be unable to re-direct financial resource to primary and community services due to rising demand for, and increased costs in, the hospital sector.
- That alternatives to hospital services are not utilised appropriately to optimum levels and that services continue to be accessed in hospital settings.
- That individuals with long term conditions will have inequitable access to services to enable to maintain mental and physical well-being.
- That patients will be harmed from inappropriate or ineffective health care resulting in poor patient outcomes.
- Not improving and maintaining patient experience due to:
  - Not using patient intelligence appropriately with providers to improve that experience.
  - Not using patient intelligence to develop commissioning plans or service specifications resulting in patient dissatisfaction.
- That the CCG does not appropriately consider people with protected characteristics due to lack of effective processes for capturing equality and diversity information resulting in a failure to reduce variation in healthcare.
- That we fail to realise our integrated commissioning ambitions due to constraints such as financial positions and capacity pressures.
- That the CCG will not deliver its financial plans due to increased growth in acute activity at rates above those funded in the CCG indicative growth in allocations.
- That the CCG will not deliver its financial plans due to not delivering its recovery plan.
- That we are unable to recruit and retain staff with the skills required to address the increasingly complex agendas facing the CCG.
- That staff morale and wellbeing decline due to increasingly challenging workloads and the consequences of continued pressure on running cost allocations.

Capacity to handle risk

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

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

- **Responsibilities of Heads of Service and Committees**
  Each principal risk has an identified Senior Management Team Lead, Governing Body Lead and Clinical Lead. This ensures clear accountability for the management and monitoring of each principal risk. Each Senior Management Team Lead, in conjunction with the other leads, is responsible for regularly reviewing the risk, including assessing the key controls for mitigating the risk,

sources of assurance, identifying positive assurance, and where gaps in control or assurance are flagged, identifying corrective action.

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

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

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

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

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

Staff Training

An annual quality check of risks is undertaken. This involves meeting with each risk owner and senior reviewer on a 1-2-1 basis to review the wording and scoring of their risks, including controls and assurances, and to deliver detailed training on the Risk Register. Each risk owner and senior reviewer is asked to sign on completion of their training to document that this work has been undertaken. Guidance is provided to accompany the training. Good practice is actively shared between risk owners both within the organisation, and through wider sharing of practice with neighbouring CCGs.

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.

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

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.

Audit Yorkshire have carried out an internal audit of the CCG's conflicts of interest management and have concluded significant assurance. The review has confirmed that the CCG has put in place arrangements to manage conflicts of interest that comply with the statutory guidance issued by NHS England. They further concluded that the CCG can demonstrate a positive approach and culture towards the management of conflicts of interest. The review has identified a small number of suggestions for improvement to the information contained on the Registers of Interest and Gifts and Hospitality, and for the need to further publicise the role of the Conflicts of Interest Guardian, which the CCG will action during 2017/18.

Data quality

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

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

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 made considerable progress to successfully embed information governance and information risk management processes within the organisation. This has been supported by results from staff awareness surveys, audits and spot checks. The CCG has continued to build on their achievement of an attainment level 2 or above in all requirements against Version 11 (2013/14) of the Information Governance Toolkit by improving overall assessment score from 70% (2013/14), to 94% (2014/15), to 95% in 2015/16, and to **100% in 2016/17**.

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

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

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

It is a nationally mandated requirement that an organisation's information assets are risk assessed on an annual basis, but more importantly this process provides assurance to the Senior Information Risk Owner (SIRO) that information contained within the assets is secure and that personal data is being processed in accordance with the Data Protection Act. The CCG has assigned Information Asset Owners to take on responsibility for information security of a range of business systems used by staff. The Information Asset Owners have completed a comprehensive review and risk assessment of their information assets to ensure that sufficient security measures and controls are in place to protect any area or system where business sensitive or person identifiable information is stored.

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 & Huddersfield NHS Foundation Trust (provider of payroll services). At the time of writing no significant issues have been reported.

Control Issues

No significant control issues have been identified.

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

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

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

The Finance & Performance Committee and Governing Body receive detailed monthly finance and contracting reports setting out the financial position including associated risks.

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

The **My NHS Quality of Leadership indicator** is based on four key lines of enquiry to determine how robustly the leaders of a CCG are performing their role. The four key lines of enquiry are:

- Robust culture and leadership sustainability
- Quality
- Governance, including financial governance
- Engagement and involvement

Evidence based assessments are made by NHS England local teams and moderated regionally and nationally. There are four levels of assessment: Green Star (highest), Green, Amber, Red (lowest).

As at the end of quarter 2, 2016-17, the CCG is rated as **Green**. The 2016/17 year-end results for the Quality of Leadership indicator will be available from July 2017 at www.nhs.uk/service-search/scorecard/results/1175.

Delegation of functions

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

Counter fraud arrangements

The CCG's Audit Committee approves an annual fraud, bribery and corruption work plan detailing planned anti-fraud activity at the CCG during the financial year. This plan is based on the NHS Protect Standards for Commissioners and is structured around the four key areas of activity:

- Strategic governance
- Inform and involve
- Prevent and deter
- Hold to account

The CCG's Local Counter Fraud Specialist (LCFS) is an NHS Accredited Counter Fraud Specialist and adheres to standards and principles of professional conduct as set out in the NHS Counter Fraud and Corruption Manual. The LCFS produces a Fraud Risk Assessment, which considers the fraud risks faced by the CCG using local and national data and NHS Protect guidance.

The LCFS reports to the Chief Finance Officer on all fraud matters including proactive work, fraud referrals and areas of risk. The Chief Finance Officer provides strategic support and oversight of anti-fraud work and ensures adequate resources are provided.

The LCFS provides an annual report of anti-fraud, bribery and corruption work, which complies with NHS Protect's guidance. This is received by the Audit Committee.

Head of Internal Audit Opinion

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

HEAD OF INTERNAL AUDIT OPINION
ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT
NHS GREATER HUDDERSFIELD CLINICAL COMMISSIONING GROUP
FOR THE YEAR ENDED 31 MARCH 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 2016/2017 the Clinical Commissioning Group's (CCG) arrangements for managing risk and providing assurance to the Governing Body have continued to be embedded.

The Governing Body has agreed an Assurance Framework that is aligned to its strategic objectives. The design of the Assurance Framework has been kept under regular review since the creation of the CCG. The Governing Body retains oversight of the design and content the Assurance Framework whilst the CCG's Audit Committee has also carried out 'deep dives' of the Assurance Framework on a number of occasions throughout the year. I

can conclude that the methodology surrounding the design and operation of the framework has been sound and has been subject to regular review by the Audit Committee.

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

The 2016/17 Internal Audit Plan was approved by the Audit Committee on 18 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 CCG's self-assessment score for the Information Governance Toolkit submission in March 2017. Further advisory work has been completed which provided a gap analysis in respect of the evidence that the CCG was planning to submit in its Information Governance Toolkit (V14) by 31 March 2017.

The outcome of the assurance audit reports as at 23 May 2017 from the 2016/2017 audit plan are summarised below. The audits in italics will be completed by 31 May 2017.

Audit	**Assurance Level**
Governance & Risk Review (Including	Significant

Assurance Framework)	
Conflicts of Interest	Significant
Business Continuity	Significant
Business Intelligence	Significant
Estates Strategy	Significant
IG Toolkit (Parts 1 and 2)	No Opinion / Significant
Financial Transactions (Parts 1 and 2)	Significant
Quality, Innovation, Productivity and Prevention (QIPP)	Significant
Primary Care Co-Commissioning	*Report in Draft (Significant)*
Personal Health Budgets	Significant
Commissioning (from a Lead Commissioner Perspective)	*Report in Draft (Significant)*
Safeguarding	*Report in Draft (Significant)*
Individual Funding Requests	Full
Capital Expenditure Bids	Significant

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

The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed.

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

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

- Governing Body keeps under review the systems of internal control through reports on risk management and the assurance framework as well as the performance, contracting, finance and quality reports.

- At a committee level the **Finance and Performance and Quality and Safety Committees** take responsibility for keeping under review the governance arrangements relating to finance, contracting, performance and clinical governance.
- The **Audit Committee** has oversight of the CCG's financial systems, financial information, risk management, audit, information governance and business continuity.
- **Auditors** provide further assurance through the delivery of their annual work plan and providing assurance as well as recommendations on different aspects within the system of internal control.
- **Self-assessment** of the risk management system and committee governance arrangements undertaken on an annual basis.
- **Financial Control Environment** - The CCG completed a self-assessment of its financial control environment in August 2015. Each CCG was required to evaluate the strength of its financial governance and controls across a range of key areas. The completed assessment was reviewed by the Audit Committee and Governing Body and discussed with the CCG's internal auditors. This is kept under review by the Audit Committee.
- **Third Party Assurance.** Alongside the Head of Internal Audit Opinion and the Annual Report, the CCG considers the assurance statements received from other service providers such as Calderdale & Huddersfield NHS Foundation Trust (provider of HR and payroll services). At the time of writing no significant issues have been reported although the formal assurance reports have not been received as yet.

Conclusions

During the year no significant internal control issues have been identified.

Carol McKenna
Accountable Officer

25 May 2017

Committee Membership and Attendance Records – 1April 2016 to 23 May 2017

Governing Body (26 meetings)	Attendance
Dr Steve Ollerton (Chair)	92%
Dr Razwan Ali (from 1 October 2016)	100%
Dr Dil Ashraf (from 1 September 2016)	88%
Dr Chris Beith	100%
Dr Irving Cobden	77%
Jenny Cullearn (from 1 September 2016)	88%
Ian Currell (from 1 October 2016)	100%
Dr Ramesh Edara (until 31 August 2016)	67%
Dr Jane Ford	85%
Dr Anuj Handa (until 30 September 2016)	50%
Dr David Hughes	77%
Dr Matthew Kaye	81%
Julie Lawreniuk (until 28 April 2016)	100%
David Longstaff	100%
Priscilla McGuire	96%
Carol McKenna	100%
Angela Monaghan	92%
Lesley Stokey (29 April – 30 September 2016)	75%
Penny Woodhead	100%

Quality & Safety Committee (13 meetings)	Attendance
Dr Jane Ford (Chair)	92%
Dr Razwan Ali (from 1 October 2016)	57%
Dr Chris Beith	77%
Dr Irving Cobden	100%
Dr Anuj Handa (until 30 September 2016)	67%
Priscilla McGuire	62%
Penny Woodhead	85%

Primary Care Commissioning Committee (15 meetings)	Attendance
Priscilla McGuire (Chair)	87%
Nigel Bell (from 1 May 2016)	79%
Dr Irving Cobden	47%
Ian Currell (from 1 October 2016)	100%
Dr Jane Ford	71%
Julie Lawreniuk (until 28 April 2016)	100%
David Longstaff	100%
Carol McKenna	100%
Dr Steve Ollerton	86%
Lesley Stokey (29 April – 30 September 2016)	80%

Finance & Performance Committee (13 meetings)	Attendance
Carol McKenna (Chair)	92%
Jenny Cullearn (from 1 September 2016)	88%
Ian Currell (from 1 October 2016)	86%
Dr Matthew Kaye	85%
Julie Lawreniuk (until 28 April 2016)	100%
David Longstaff	77%
Dr Steve Ollerton	77%
Lesley Stokey (29 April – 30 September 2016)	100%

Audit Committee (7 meetings)	Attendance
David Longstaff (Chair)	100%
Dr Matthew Kaye	100%
Priscilla McGuire	86%
Angela Monaghan	86%

Remuneration Committee (6 meetings)	Attendance
David Longstaff (Chair)	100%
Priscilla McGuire	83%
Angela Monaghan	83%

Recovery Committee (4 meetings)	Attendance
Dr Steve Ollerton (Chair	100%
Dr Dil Ashraf	100%
Nigel Bell	100%
Dr Irving Cobden	50%
Ian Currell (from 1 October 2016)	100%
Dr David Hughes	100%
Dr Matthew Kaye	100%
Priscilla McGuire	75%
Carol McKenna	100%
Lesley Stokey (29 April – 30 September 2016)	100%

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report 2016/17

Remuneration & Staff Report

Carol McKenna
Accountable Officer

25 May 2017

Remuneration Committee

Details of the members of the Remuneration Committee can be found within the Governance Statement (page 79).

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

Policy on the remuneration of senior managers

The definition of 'senior managers' is: *Those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group. This means those who influence the decisions of the Clinical Commissioning Group as a whole rather than the decisions of individual directorates or departments. Such persons will include advisory or lay members.*

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

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

Hutton review fair pay principles (2011):

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

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

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

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

In determining the appropriate rate, the Remuneration Committee also took into account:
- The key and guiding principles set out
- Comparative rates for each of the Governing Body posts
- The requirement to obtain best value for money
- The need for an affordable staffing and remuneration structure within its running cost allowance.

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

For practice representatives on the Governing Body, including the clinical Chair, remuneration should be either:
- At a reasonable rate, in line with practice earnings;
- At a rate commensurate with allowing backfill, recognising that a locum cannot replace an experienced partner on a like for like basis, and that some additional locum time would be necessary;
- In line with any local sessional rate.

In respect of the clinical chair's remuneration, the CCG is satisfied, on the basis of what it has considered, that the chair's salary is reasonable.

For the Accountable Officer and the Chief Finance Officer, which are subject to VSM terms and conditions, consideration also took account of:
- Pay benchmarking information provided by the NHS Commissioning Board
- Complexity factors
- Availability of guidance on recruitment and retention premiums
- Prevailing economic climate and local market conditions
- Any joint management arrangements

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

This approach will be retained in respect of any new determinations for 2017/18.

Senior manager remuneration (including salary and pension entitlements)

Name & Title		2016-17 Staff in Post	2016-17					
			Salary	Expense payments (taxable)	Performance pay and bonuses	Long-term Performance pay and bonuses	All Pension Related Benefits (Note 3)	Total
			(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
			£000	£000	£000	£000	£000	£000
Dr Stephen Ollerton	Clinical Leader	01/04/2016 to 31/03/2017	90 - 95				35 - 37.5	125 - 130
Dr Jane Ford	Deputy Clinical Leader	01/04/2016 to 31/03/2017	45 - 50					45 - 50
Dr Dilshad Ashraf	Practice Representative	01/09/2016 to 31/03/2017	15 - 20					15 - 20
Dr Razwan Ali	Practice Representative	01/10/2016 to 31/03/2017	15 - 20					15 - 20
Dr Anuj Handa	Practice Representative	01/04/2016 to 30/09/2016	20 - 25					20 - 25
Dr David Hughes	Practice Representative	01/04/2016 to 31/03/2017	30 - 35					30 - 35
Dr Ramesh Edara	Practice Representative	01/04/2016 to 31/08/2016	5 - 10					5 - 10
Dr Matthew Kaye	Practice Representative	01/04/2016 to 31/03/2017	45 - 50					45 - 50
Dr Chris Beith	Practice Representative	01/04/2016 to 31/03/2017	45 - 50					45 - 50
Jenny Cullearn	Practice Representative	01/09/2016 to 31/03/2017	5 - 10					5 - 10
Nigel Bell	Lay Advisor	01/05/2016 to 31/03/2017	5 - 10					5 - 10
Priscilla McGuire	Lay member (Patient and Public Involvement)	01/04/2016 to 31/03/2017	10 - 15					10 - 15
David Longstaff	Lay Member (Audit)	01/04/2016 to 31/03/2017	10 - 15					10 - 15
Dr Irving Cobden	Secondary Care Advisor	01/04/2016 to 31/03/2017	15 - 20					15 - 20
Angela Monaghan	Nurse Advisor	01/04/2016 to 31/03/2017	10 - 15					10 - 15
Carol McKenna	Chief Officer	01/04/2016 to 31/03/2017	120 - 125				52.5 - 55	170 - 175
Julie Lawreniuk	Chief Finance Officer **(Note 1)**	01/04/2016 to 30/04/2016	0 - 5				2.5 - 5	5 - 10
Lesley Stokey	Acting Chief Finance Officer **(Note 2)**	01/05/2016 to 30/09/2016	15 - 20				35 - 37.5	55 - 60
Ian Currell	Chief Finance Officer **(Note 3)**	01/10/2016 to 31/03/2017	50 - 55				12.5 - 15	65 - 70
Penny Woodhead	Head of Quality and Safety **(Note 4)**	01/04/2016 to 31/03/2017	25 - 30					25 - 30

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

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

Note 2: Lesley Stokey is employed by Calderdale CCG but is a shared post also with Greater Huddersfield CCG. She was Acting Chief Financial Officer between Julie Lawreniuk and Ian Currell.

Note 3: Ian Currell, the incoming Chief Financial Officer, is employed by Greater Huddersfield CCG and is not a shared post.

Note 4: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale & North Kirklees CCGs, for whom she is also Head of Quality. Her total salary is in the banding £75k - 80k, however, only 33% has been included in the Salary & Fees column.

Note 5: The amounts included in All Pension Related Benefits is the annual increase in pension entitlement determined in accordance with the 'HMRC' method.

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

• Where:

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

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

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

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

Pension benefits as at 31 March 2017

			2016-17							
Name & Title		2016-17 Staff in Post	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31 March 2017	Lump sum at pension age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017	Employer's contribution to partnership pension
			(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
			£000	£000	£000	£000	£000	£000	£000	£000
Dr Stephen Ollerton	Clinical Leader	01/04/2016 to 31/03/2017	0 - 2.5	0 - 2.5	10 - 15	25 - 30	138	28	166	14
Carol McKenna	Chief Officer	01/04/2016 to 31/03/2017	2.5 - 5	0 - 2.5	35 - 40	105 - 110	603	47	649	23
Julie Lawreniuk	Chief Finance Officer	01/04/2016 to 31/04/2016	0 - 2.5	0 - 2.5	35 - 40	105 - 110	654	44	698	2
Lesley Stokey	Acting Chief Finance Officer	01/05/2016 to 30/09/2016	0 - 2.5	0 - 2.5	15 - 20	35 - 40	167	37	204	8
Ian Currell	Chief Finance Officer	01/10/2016 to 31/03/2017	0 - 2.5	- 2.5 - 0	35 - 40	100 - 105	601	25	626	6

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

Note 1: Julie Lawreniuk was employed by Calderdale CCG but was a shared post also with Greater Huddersfield CCG, for whom she was also Chief Financial Officer. The above info includes the full pension information, not a proportion in relation to the shared post. However the figures in 'Real increase in pension at pension age' and 'Real increase in pension lump sum at pension age' are proportional to the length of time in post.

Note 2: Lesley Stokey is employed by Calderdale CCG but is a shared post also with Greater Huddersfield CCG. She was Acting Chief Financial Officer between Julie Lawreniuk and Ian Currell. The above info includes the full pension information, not a proportion in relation to the shared post. However the figures in 'Real increase in pension at pension age' and 'Real increase in pension lump sum at pension age' are proportional to the length of time in post.

Note 3: Ian Currell, the incoming Chief Financial Officer, is employed by Greater Huddersfield CCG and is not a shared post. However the figures in 'Real increase in pension at pension age' and 'Real increase in pension lump sum at pension age' are proportional to the length of time in post.

Note 4: NHS Pensions Agency has stated that they cannot provide pension benefits information for Governing Body GPs who are classed only as practitioners with NHS Pensions Agency, and also where they have a contract for service with the CCG. As a result the CCG is not able to show the pension benefits related to their role as a governing body member. The CCG pays over the pension contributions to NHS England who act as the NHS Pension Employing Authority for these GPs.

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 made compensation for redundancy payments of £128k in total to two members of staff during the year in accordance with NHS Terms and Conditions of Service Handbook (Agenda for Change).

One of the redundancies (for £83k) was shared equally across seven CCGs as the post is shared.

Payments to past very senior managers

The CCG has not made any such payments in 2016/17.

Pay multiples

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

The banded remuneration of the highest paid member of the Governing Body of the CCG in the financial year 2016/17 was £140k – £145k (2015/16: £140k - £145k). This is based on a Full Time Equivalent (FTE) salary. This was 4.2 times (2015/16: 3.9) the median remuneration of the workforce, which was £33,560 (2015/16: £35,891).

In 2016/17, no employees received remuneration in excess of the highest-paid member of the Governing Body. Remuneration ranged from £16,800 to £142,865 (2015/2016: £16,633 to £141,250).

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

The change to the median remuneration of the workforce is due to the closedown of the Yorkshire & Humber Commissioning Support (CSU) at the end of 2015 and the subsequent in-housing of a number of services previously provided by the CSU resulting in an increase to the number of employed staff.

Staff Report

Number of senior managers

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

Staff numbers and costs (average number of people employed)

	31st March 2017			2015-16
	Permanent Employees Number	Other Number	Total Number	Total Number
	N4Q	N4R	N4S	N4S1
Total CCG	**51.2**	**26.9**	**78**	**63**
Of the above:				
Number of whole time equivalent people engaged on capital projects	0	0	**0**	0

2016-17 Staff costs and employee benefits	2016-17 Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	4,141	2,879	1,262	3,101	2,325	776	1,039	554	486
Social security costs	385	304	81	281	243	38	103	60	43
Employer Contributions to NHS Pension scheme	461	365	96	338	293	45	123	71	52
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	128	128	0	128	128	0	0	0	0
Gross employee benefits expenditure	**5,115**	**3,675**	**1,439**	**3,849**	**2,990**	**859**	**1,266**	**686**	**580**
Less recoveries in respect of employee benefits	(1,323)	(1,323)	0	(1,043)	(1,043)	0	(280)	(280)	0
Total - Net admin employee benefits including capitalised costs	**3,791**	**2,352**	**1,439**	**2,806**	**1,947**	**859**	**986**	**405**	**580**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,791**	**2,352**	**1,439**	**2,806**	**1,947**	**859**	**986**	**405**	**580**

2015-16 Staff costs and employee benefits	2015-16 Total			Admin			Programme		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits									
Salaries and wages	3,024	2,173	851	2,235	1,715	520	789	457	331
Social security costs	233	186	48	169	147	22	64	39	25
Employer Contributions to NHS Pension scheme	352	283	69	257	226	31	95	57	38
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**3,609**	**2,641**	**968**	**2,662**	**2,088**	**574**	**947**	**553**	**394**
Less recoveries in respect of employee benefits	(530)	(530)	0	(357)	(357)	0	(173)	(173)	0
Total - Net admin employee benefits including capitalised costs	**3,080**	**2,112**	**968**	**2,305**	**1,732**	**574**	**774**	**380**	**394**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,080**	**2,112**	**968**	**2,305**	**1,732**	**574**	**774**	**380**	**394**

Staff composition

The following tables show the composition of the CCG's employed workforce as at 31 March 2017:

Gender Profile of the CCG

	Headcount	
	Male	Female
Members of the Governing Body	8	4
Very senior managers	1	2
All other employees not included above	15	68

Age Profile of the CCG (excluding Governing Body)

Age Range	Headcount
<25	<5
26-30	5
31-35	6
36-40	20
41-45	15
46-50	14
51-55	15
56-60	9
61-65	<5

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

Ethnicity	Headcount
White	75
Mixed ethnic origin	<5
Asian/Asian British	7
Black/Black British	<5
Not Stated	<5

Sickness absence data

	2016-17 Number	2015-16 Number
Total Days Lost	442	278
Total Staff Years	76	56
Average working Days Lost	6	5

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

Staff policies

The CCG has a range of HR related policies in place which are accessible to colleagues using the CCG's intranet system. Policies are reviewed in line with the internal governance arrangements and involve staff side and trade union representatives as appropriate. Final approval regarding any new or amended policies lies with the CCG's Remuneration Committee.

Expenditure on consultancy

In 2016/17, the CCG has spent £164k on consultancy fees.

Off payroll engagements

Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2017	7
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	1
for between 3 and 4 years at the time of reporting	4
for 4 or more years at the time of reporting	

The CCG can confirm that all existing off-payroll engagement have at some point been subject to a risk based assessment as to whether assurance is require that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

New off-payroll engagements

For all new off-payroll engagements between 01 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	1
Number of new engagements which include contractual clauses giving Greater Huddersfield CCG the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested	1
Of which:	
assurance has been received	1
assurance has not been received	0
engagements terminated as a result of assurance not being received.	0

Off-payroll engagements / senior official engagements

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements.	20

Exit packages, including special (non-contractual) payments

Table 1: Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	0	0	0	0	0	0
£25,001 - £50,000	1	45,510	0	0	1	45,510	0	0
£50,001 - £100,000	1	82,746 (Note 1)	0	0	1	82,746 (Note 1)	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	2	128,256	0	0	2	128,256	0	0

Note 1: Shared across 7 organisations = £11,820.86 each

Redundancy and other departure costs have been paid in accordance with the provisions of NHS Terms & Conditions of Service Handbook (Agenda for Change). Exit costs in this note are accounted for in full in the year of departure. Where Greater Huddersfield CCG has agreed early retirements, the additional costs are met by Greater Huddersfield CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Table 2: Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	£000s
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice*	**0**	**0**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**0**	**0**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Table 1 which will be the number of individuals.

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.

**includes any non-contractual severance payment made following judicial mediation, and X (list amounts) relating to non-contractual payments in lieu of notice.

0 non-contractual payments were made to individuals where the payment value was more than 12 months’ of their annual salary.

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

Parliamentary Accountability & Audit Report

Greater Huddersfield CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at note 5, note 31 and note 39. An audit certificate and report is also included in this Annual Report at page 128.

NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Accounts 2016/17

Carol McKenna
Accountable Officer

25 May 2017

FOREWORD TO THE ACCOUNTS

GREATER HUDDERSFIELD CCG

These accounts for the year ended 31 March 2017 have been prepared by
Greater Huddersfield CCG under the Health and Social Care Act 2012
in the form which the Secretary of State has, with the approval of the Treasury, directed.

NHS Greater Huddersfield CCG - Annual Accounts 2016-17

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

NHS Greater Huddersfield CCG - Annual Accounts 2016-17

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	(1,982)	(3,028)
Other operating income	2	(1,700)	(848)
Total operating income		**(3,682)**	**(3,876)**
Staff costs	4	5,115	3,609
Purchase of goods and services	5	328,754	286,962
Depreciation and impairment charges	5	46	55
Provision expense	5	0	0
Other Operating Expenditure	5	472	3,137
Total operating expenditure		**334,387**	**293,763**
Net Operating Expenditure		**330,705**	**289,887**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**330,705**	**289,887**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**330,705**	**289,887**
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		**330,705**	**289,887**

The notes on pages 101 to 128 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	90	99
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		90	99
Current assets:			
Inventories	16	1,329	951
Trade and other receivables	17	2,978	1,671
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	10	30
Total current assets		**4,317**	2,652
Non-current assets held for sale	21	0	0
Total current assets		**4,317**	2,652
Total assets		**4,407**	2,751
Current liabilities			
Trade and other payables	23	(18,071)	(15,381)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		**(18,071)**	(15,381)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(13,664)**	(12,630)
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		**(13,664)**	(12,630)
Financed by Taxpayers' Equity			
General fund		(13,664)	(12,630)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(13,664)**	(12,630)

The notes on pages 101 to 128 form part of this statement

The financial statements on pages 97 to 100 were approved by the Audit Committee on 24 May 2017 and signed on its behalf by:

Chief Accountable Officer
Carol McKenna

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	(12,630)	0	0	**(12,630)**
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	**(12,630)**	**0**	**0**	**(12,630)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(330,705)			(330,705)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(330,705)**	**0**	**0**	**(330,705)**
Net funding	329,671	0	0	329,671
Balance at 31 March 2017	**(13,664)**	**0**	**0**	**(13,664)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(13,216)**	**0**	**0**	**(13,216)**
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	**(13,216)**	**0**	**0**	**(13,216)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(289,887)			(289,887)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(289,887)**	**0**	**0**	**(289,887)**
Net funding	290,473	0	0	290,473
Balance at 31 March 2016	**(12,630)**	**0**	**0**	**(12,630)**

The notes on pages 101 to 128 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		(330,705)	(289,887)
Depreciation and amortisation	5	46	55
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		(378)	(565)
(Increase)/decrease in trade & other receivables	17	(1,308)	(886)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	2,690	873
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		**(329,655)**	(290,410)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(36)	(47)
(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		**(36)**	(47)
Net Cash Inflow (Outflow) before Financing		**(329,691)**	(290,457)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		329,671	290,473
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		**329,671**	290,473
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(20)**	16
Cash & Cash Equivalents at the Beginning of the Financial Year		**30**	14
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		**10**	30

The notes on pages 101 to 128 form part of this statement

NHS Greater Huddersfield CCG - Annual Accounts 2016-17

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.

Notes to the financial statements

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

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

1.7.2 **Key Sources of Estimation Uncertainty**

The CCG has made a estimate for Prescribing accrual based on the latest available NHS Business Service Authority information.

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

1.11.2 **Valuation**

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

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

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

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

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

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

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

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

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

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

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.
The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.
Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 **Leases**

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

Notes to the financial statements

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

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

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

1.18 **Private Finance Initiative Transactions**

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

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

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

1.18.1 **Services Received**

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

1.18.2 **PFI Asset**

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

1.18.3 **PFI Liability**

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

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

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

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

1.18.4 **Lifecycle Replacement**

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

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

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

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

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

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

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

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

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

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

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

Notes to the financial statements

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

1.19 **Inventories**

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

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**

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

1.26 **Contingencies**

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

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

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

Notes to the financial statements

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

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

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

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

1.27.4 **Loans & Receivables**

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

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

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

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

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

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

1.28 **Financial Liabilities**

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

Notes to the financial statements

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

1.33 **Subsidiaries**

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

1.34 **Associates**

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

1.35 **Joint Ventures**

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

1.36 **Joint Operations**

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

1.37 **Research & Development**

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 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	1,323	1,043	280	530
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	30	30	0	3
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	1,952	317	1,635	3,024
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	377	10	367	319
Total other operating revenue	**3,682**	**1,400**	**2,282**	**3,876**

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

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

3 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	3,682	1,400	2,282	3,876
From sale of goods	0	0	0	0
Total	**3,682**	**1,400**	**2,282**	**3,876**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2016-17	Total	Permanent Employees	Other
	Total £'000	£'000	£'000
Employee Benefits			
Salaries and wages	4,141	2,879	1,262
Social security costs	385	304	81
Employer Contributions to NHS Pension scheme	461	365	96
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	128	128	0
Gross employee benefits expenditure	**5,115**	**3,676**	**1,439**
Less recoveries in respect of employee benefits (note 4.1.2)	(1,323)	(1,293)	(30)
Total - Net admin employee benefits including capitalised costs	**3,792**	**2,383**	**1,409**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,792**	**2,383**	**1,409**

4.1.1 Employee benefits

2015-16	Total	Permanent Employees	Other
	Total £'000	£'000	£'000
Employee Benefits			
Salaries and wages	3,024	2,173	851
Social security costs	234	186	48
Employer Contributions to NHS Pension scheme	352	283	69
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	**3,610**	**2,642**	**968**
Less recoveries in respect of employee benefits (note 4.1.2)	(530)	(530)	0
Total - Net admin employee benefits including capitalised costs	**3,080**	**2,112**	**968**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,080**	**2,112**	**968**

4.1.2 Recoveries in respect of employee benefits

2016-17	Total	Permanent Employees	Other	2015-16 Total
	Total £'000	£'000	£'000	£'000
Employee Benefits - Revenue				
Salaries and wages	(1,113)	(1,083)	(30)	(440)
Social security costs	(102)	(102)	0	(39)
Employer contributions to the NHS Pension Scheme	(108)	(108)	0	(51)
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	**(1,323)**	**(1,293)**	**(30)**	**(530)**

4.2 Average number of people employed

	2016-17 Total Number	2016-17 Permanently employed Number	2016-17 Other Number	2015-16 Total Number
Total	**78**	**51**	**27**	**63**
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	442	278
Total Staff Years	76	56
Average working Days Lost	6	5

	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

	2016-17 Compulsory redundancies Number	2016-17 Compulsory redundancies £	2016-17 Other agreed departures Number	2016-17 Other agreed departures £	2016-17 Total Number	2016-17 Total £
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	45,510	0	0	1	45,510
£50,001 to £100,000	1	82,746	0	0	1	82,746
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**128,256**	**0**	**0**	**2**	**128,256**

	2015-16 Compulsory redundancies Number	2015-16 Compulsory redundancies £	2015-16 Other agreed departures Number	2015-16 Other agreed departures £	2015-16 Total Number	2015-16 Total £
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2016-17 Departures where special payments have been made Number	2016-17 Departures where special payments have been made £	2015-16 Departures where special payments have been made Number	2015-16 Departures where special payments have been made £
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2016-17 Other agreed departures Number	2016-17 Other agreed departures £	2015-16 Other agreed departures Number	2015-16 Other agreed departures £
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**0**	**0**	**0**	**0**

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 (England) of the NHS terms and conditions of service handbook.

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 Accounting valuation

Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM

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

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the 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

For 2016-17, employers' contributions of £365k were payable to the NHS Pensions Scheme (2015-16: £283k) 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	4,772		3,506	1,266	3,309
Executive governing body members	343		343	0	300
Total gross employee benefits	**5,115**		**3,849**	**1,266**	**3,609**
Other costs					
Services from other CCGs and NHS England	1,324	**	429	895	3,898
Services from foundation trusts	160,331		358	159,973	154,293
Services from other NHS trusts	22,597		0	22,597	21,132
Services from other WGA bodies	0		0	0	0
Purchase of healthcare from non-NHS bodies	72,287		0	72,287	67,739
Chair and Non Executive Members	472		472	0	544
Supplies and services – clinical	13		0	13	(7)
Supplies and services – general	310		176	134	246
Consultancy services	224		103	121	45
Establishment	638		473	165	182
Transport	4		3	1	5
Premises	3,213		282	2,931	2,593
Impairments and reversals of receivables	0		0	0	0
Inventories written down and consumed	0		0	0	0
Depreciation	46		46	0	55
Amortisation	0		0	0	0
Impairments and reversals of property, plant and equipment	0		0	0	0
Impairments and reversals of intangible assets	0		0	0	0
Impairments and reversals of financial assets					
· Assets carried at amortised cost	0		0	0	0
· Assets carried at cost	0		0	0	0
· Available for sale financial assets	0		0	0	0
Impairments and reversals of non-current assets held for sale	0		0	0	0
Impairments and reversals of investment properties	0		0	0	0
Audit fees	59		59	0	59
Other non statutory audit expenditure					
· Internal audit services	0	*	0	0	0
· Other services	(10)		(10)	0	10
General dental services and personal dental services	0		0	0	0
Prescribing costs	37,265		0	37,265	37,708
Pharmaceutical services	0		0	0	0
General ophthalmic services	189		0	189	122
GPMS/APMS and PCTMS	29,747	***	0	29,747	326
Other professional fees excl. audit	82		30	52	10
Grants to Other bodies	0		0	0	0
Clinical negligence	0		0	0	0
Research and development (excluding staff costs)	0		0	0	0
Education and training	37		37	0	79
Change in discount rate	0		0	0	0
Provisions	0		0	0	0
Funding to group bodies			0	0	0
CHC Risk Pool contributions	446		0	446	1,115
Other expenditure	0		0	0	0
Total other costs	**329,274**		**2,458**	**326,816**	**290,154**
Total operating expenses	**334,389**		**6,307**	**328,082**	**293,763**

* Internal Audit services of £35k for 2016-17 and £35k for 2015-16 have been provided by Calderdale & Huddersfield Foundation Trust are included in Services from Foundation Trusts

** Included in Services from CCG's and NHS England in 2016-17 is £338k (2015-16 £1,181k) of payments made by Calderdale CCG on behalf of Greater Huddersfield CCG for the work of the systems resilience group across Calderdale and Huddersfield

*** GPMS/APMSand PCTMS included £29,545k for delegated responsibility for commissioning primary medical services for 2016-17

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	4,619	79,372	3,027	47,566
Total Non-NHS Trade Invoices paid within target	4,366	78,116	2,916	47,459
Percentage of Non-NHS Trade invoices paid within target	**94.52%**	**98.42%**	**96.33%**	**99.77%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,889	213,718	2,497	205,604
Total NHS Trade Invoices Paid within target	2,763	209,820	2,450	203,635
Percentage of NHS Trade Invoices paid within target	**95.64%**	**98.18%**	**98.12%**	**99.04%**

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

	2016-17 £'000	2015-16 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

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

8. Investment revenue

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

9. Other gains and losses

The clinical commissioning group has no other gains and losses.

10. Finance costs

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

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

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

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2016-17				2015-16			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense								
Minimum lease payments	0	3,193	(0)	**3,193**	0	2,646	(0)	**2,646**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**3,193**	**(0)**	**3,193**	**0**	**2,646**	**(0)**	**2,646**

12.1.2 Future minimum lease payments

	2016-17				2015-16			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	Land £'000	Buildings £'000	Other £'000	Total £'000
Payable:								
No later than one year	0	3,193	0	**3,193**	0	-	-	**0**
Between one and five years	0	12,772	0	**12,772**	0	-	-	**0**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

The clinical commissioning group occupies property owned and managed by NHS Property Services Ltd. The annual rent charge is reflected in Note 12.1.1.
While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. Consequently, this note assumes that we be paying the 2016-17 lease payments as a minimum for each of the next 5 years.

12.2 As lessor

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

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	115	139	254
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	36	0	36
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**	**151**	**139**	**290**
Depreciation 01 April 2016	0	0	0	0	0	0	71	83	154
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	18	28	46
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**	**89**	**111**	**200**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**62**	**28**	**90**
Purchased	0	0	0	0	0	0	62	28	90
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**	**62**	**28**	**90**
Asset financing:									
Owned	0	0	0	0	0	0	62	28	90
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**	**62**	**28**	**90**

Revaluation Reserve Balance for Property, Plant & Equipment

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

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction

The clinical commissioning group has no assets under construction as at 31st March 2017.

13.2 Donated assets

The clinical commissioning group has no donated assets as at 31st March 2017.

13.3 Government granted assets

The clinical commissioning group has no government granted assets as at 31st March 2017.

13.4 Property revaluation

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

13.5 Compensation from third parties

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

13.6 Write downs to recoverable amount

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

13.7 Temporarily idle assets

The clinical commissioning group has no temporarily idle assets as at 31st March 2017.

13.8 Cost or valuation of fully depreciated assets

None of the clinical commissioning groups assets are fully depreciated as at 31st March 2017.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	3	3
Furniture & fittings	5	5

14 Intangible non-current assets

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

15 Investment property

The clinical commissioning group had no investment property as at 31 March 2017.

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	951	951
Additions	0	0	0	0	0	378	378
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**	**1,329**	**1,329**

These inventories are for community equipment.

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	420	0	1,023	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	143	0	215	0
NHS accrued income	25	0	69	0
Non-NHS and Other WGA receivables: Revenue	248	0	143	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	1,728	0	75	0
Non-NHS and Other WGA accrued income	416	0	146	0
Provision for the impairment of receivables	0	0	0	0
VAT	(0)	0	0	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	(2)	0	0	0
Total Trade & other receivables	**2,978**	**0**	**1,671**	**0**
Total current and non current	**2,978**		**1,671**	
Included above:				
Prepaid pensions contributions	0		0	

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

17.1 Receivables past their due date but not impaired	2016-17 £'000	2015-16 £'000
By up to three months	6	3
By three to six months	0	0
By more than six months	0	0
Total	**6**	**3**

None of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2017.

17.2 Provision for impairment of receivables

The clinical commissioning group held no provisions for impairment of recievables as at 31 March 2017.

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2017.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2017.

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	30	14
Net change in year	(20)	16
Balance at 31 March 2017	**10**	**30**
Made up of:		
Cash with the Government Banking Service	10	30
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	**10**	**30**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**10**	**30**

Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale

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

22 Analysis of impairments and reversals

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

23 Trade and other payables	Current 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	1,001	0	1,216	0
NHS payables: capital	0	0	0	0
NHS accruals	2,230	0	1,964	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	1,867	0	1,487	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	11,572	0	10,196	0
Non-NHS and Other WGA deferred income	6	0	46	0
Social security costs	52	0	39	0
VAT	0	0	0	0
Tax	43	0	39	0
Payments received on account	0	0	0	0
Other payables and accruals	1,299	0	394	0
Total Trade & Other Payables	**18,070**	**0**	**15,381**	**0**
Total current and non-current	**18,070**		**15,381**	

Other payables include £57k outstanding pension contributions at 31 March 2017.

24 Other financial liabilities

The clinical commissioning group has no other financial liabilities as at 31st March 2017.

25 Other liabilities

The clinical commissioning group has no other liabilities as at 31st March 2017.

26 Borrowings

The clinical commissioning group has no borrowings as at 31st March 2017.

27 Private finance initiative, LIFT and other service concession arrangements

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

28 Finance lease obligations

The clinical commissioning group has no finance lease obligations as at 31st March 2017.

29 Finance lease receivables

The clinical commissioning group has no finance leases receivable as at 31st March 2017.

30 Provisions

	Pensions Relating to Former Directors £'000	Pensions Relating to Other Staff £'000	Restructuring £'000	Redundancy £'000	Agenda for Change £'000	Equal Pay £'000	Legal Claims £'000	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Arising during the year	0	0	0	0	0	0	0	0	0	0
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	0	0	0
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body under absorption	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	0	0	0
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provision accounted for by NHS England on behalf of Greater Huddersfield CCG at 31 March 2017 is £738k (31 March 2016 £1,595k).

31 Contingencies

The clinical commissioning group has no contingent liabilities or assets.

32 Commitments

32.1 Capital commitments

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

32.2 Other financial commitments

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

33 Financial instruments

33.1 Financial risk management

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

Because 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	445	0	445
· Non-NHS	0	664	0	664
Cash at bank and in hand	0	10	0	10
Other financial assets	0	(2)	0	(2)
Total at 31 March 2017	**0**	**1,117**	**0**	**1,117**

	At 'fair value through profit and loss' 2015-16 £'000	Loans and Receivables 2015-16 £'000	Available for Sale 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,092	0	1,092
· Non-NHS	0	289	0	289
Cash at bank and in hand	0	30	0	30
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**1,411**	**0**	**1,411**

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	3,232	3,232
· Non-NHS	0	14,738	14,738
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**	**17,970**	**17,970**

	At 'fair value through profit and loss' 2015-16 £'000	Other 2015-16 £'000	Total 2015-16 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,180	3,180
· Non-NHS	0	12,077	12,077
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**	**15,257**	**15,257**

33.4 Maturity of financial liabilities

The clinical commissioning group has a financial liability of £17,9706k as at the 31st March 2017. All of this liability will be settled within the financial year ending 31st March 2018.

33.5 The entity's exposure to risk

The clinical commissioning group does not have any significant exposure to credit risk as at 31st March 2017.

34 Operating segments

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

34.1 Reconciliation between Operating Segments and SoCNE

	2016-17 £'000	2015-16 £'000
Total net expenditure reported for operating segments	330,705	289,887
Reconciling items:	0	0
Total net expenditure per the Statement of Comprehensive Net Expenditure	**330,705**	**289,887**

34.2 Reconciliation between Operating Segments and SoFP

	2016-17 £'000	2015-16 £'000
Total assets reported for operating segments	4,407	2,751
Reconciling items:	0	0
Total assets per Statement of Financial Position	**4,407**	**2,751**

	2016-17 £'000	2015-16 £'000
Total liabilities reported for operating segments	(18,070)	(15,381)
Reconciling items:	0	0
Total liabilities per Statement of Financial Position	**(18,070)**	**(15,381)**

35 Pooled budgets

35.1 Community Equipment Service

Greater Huddersfield Clinical Commissioning Group has entered into a pooled budget for Community Equipment Service Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the community equipment service.

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

	2016-17	2015-16
	£000	£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	2,799	3,233
Management Overheads	200	150
Total Expenditure	**2,999**	**3,383**
Net (Surplus)/Deficit	**(690)**	**(805)**

35.2 Better Care Fund

On 1st April 2015 Greater Huddersfield Clinical Commissioning Group entered into a pooled budget arrangement for Better Care Fund with North Kirklees Clinical Commissioning Group and Kirklees Metropolitan Council. The service is hosted by Kirklees Metropolitan Council.

Under the arrangement, funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

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

	2016-17	2015-16
	£000	£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**
	0	**0**

As at 31st March 2017 Greater Huddersfield CCG had no accruals or creditors for Better Care Fund

36 NHS Lift investments

The clinical commissioning group has no NHS LIFT investments.

37 Related party transactions

Representatives from the GP practices below were members of our Governing Body during 2016-17 and/or 2015-16. Their practices received remuneration from the CCG for services to patients. The amounts involved are disclosed below. The remuneration of individual Executive Governing Body members is disclosed within the CCG's Remuneration Report section of the Annual Report.

Details of related party transactions with individuals are as follows:

	Payments to Related Party 2016-17 £000	**Receipts from Related Party 2016-17 £000**	**Amounts owed to Related Party 2016-17 £000**	**Amounts due from Related Party 2016-17 £000**	Payments to Related Party 2015-16 £000	Receipts from Related Party 2015-16 £000	Amounts owed to Related Party 2015-16 £000	Amounts due from Related Party 2015-16 £000
Elmwood (Dr David Hughes)	1,945		53		138		10	
Colne Valley (Dr Ramesh Edara)	293		35		67		12	
Lindley Group (Dr Matt Kaye)	1,150		52		116		10	
The Grange (Dr Jane Ford)	2,073		83		147		8	
Meltham Group (Dr Dilshad Ashraf)	852		36		80		2	
Netherton (Dr Chris Beith)	1,051		35		57		9	
Skelmanthorpe (Dr Steve Ollerton)/(Ms Jenny Cullearn)	1,183		48		93		4	
Fartown (Dr Anuj Handa)	426		28		15		2	
Junction Surgery (Dr Razwan Ali)	690		41		0		0	

In 2016-17 the clinical commissioning group assumed co-commissioning responsibility for Primary Care Contracts and as a result the value of related party transactions has increased significantly during the year.

The parent entity for the CCG is NHS England. The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

	2016-17 £000	2015-16 £000
Calderdale & Huddersfield NHS Foundation Trust	126,546	121,159
Prescription Pricing Authority	36,232	36,615
South West Yorkshire Partnership NHS Foundation Trust	23,286	23,189
Yorkshire Ambulance Service NHS Trust	12,457	11,663
Leeds Teaching Hospitals NHS Trust	7,333	6,672
Barnsley Hospital NHS Foundation Trust	4,239	3,660
Bradford Teaching Hospitals NHS Foundation Trust	2,485	2,667
NHS North Kirklees CCG	2,171	856
Mid Yorkshire Hospitals NHS Trust	2,084	2,082
NHS Property Services	1,690	2,647
NHS Calderdale CCG	966	1,551
Sheffield Teaching Hospitals NHS Foundation Trust	924	899
NHS Yorkshire & The Humber CSU	628	2,208

Julie Lawreniuk (1 April to 30th April) and Lesley Stokey (1 May to 30 September) acted in the role as the Chief Finance Officer of both Greater Huddersfield CCG and Calderdale CCG, but had no material transactions with either organisations.

David Longstaff is the Audit Lay Member for both Greater Huddersfield CCG and Calderdale CCG, but had no material transactions.

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

	2016-17 £000	2015-16 £000
Kirklees Metropolitan Council	9,943	9,546

38 Events after the end of the reporting period

From 1st April 2017, Greater Huddersfield CCG will enter into a new pooled budget arrangment 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 Greater Huddersfield Clinical Commissioning Group will contribute £1.9m.

39 Losses and special payments

The clinical commissioning group has incurred no losses or made any special payments in the year ending 31st March 2017.

40 Third party assets

The clinical commissioning group does not hold any cash or cash equivalents 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	335,151	334,424	296,740	293,800
Capital resource use does not exceed the amount specified in Directions	50	36	39	37
Revenue resource use does not exceed the amount specified in Directions	331,419	330,705	292,825	289,887
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	5,298	4,967	5,550	5,307

The clinical commissioning group received revenue resource allocations totalling £331,419k and had net expenditure of £330,705k, delivering a surplus of £714k.

42 Impact of IFRS

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

43 Analysis of charitable reserves

The clinical commissioning group has no charitable reserves.

KPMG

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

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

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, 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

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

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or

- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Certificate

We certify that we have completed the audit of the accounts of NHS Greater Huddersfield 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

26 May 2017