NHS
Greater Huddersfield
Clinical Commissioning Group

NHS Greater Huddersfield CCG Annual Report and Accounts 2020 - 21

Contents

NHS
Greater Huddersfield
Clinical Commissioning Group

Annual Report

NHS
Greater Huddersfield
Clinical Commissioning Group

Performance Report

Carol McKenna

Chief Officer

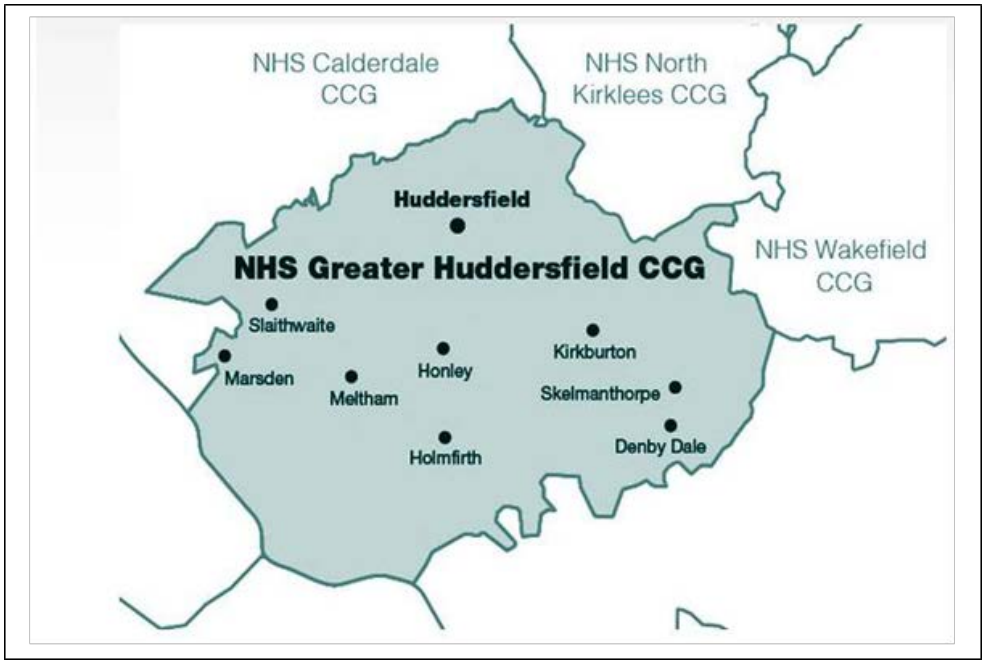
11 June 2021

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.

The CCG works closely with North Kirklees CCG, and in November 2020 we agreed to work towards a merger of the two CCGs from 1 April 2021.

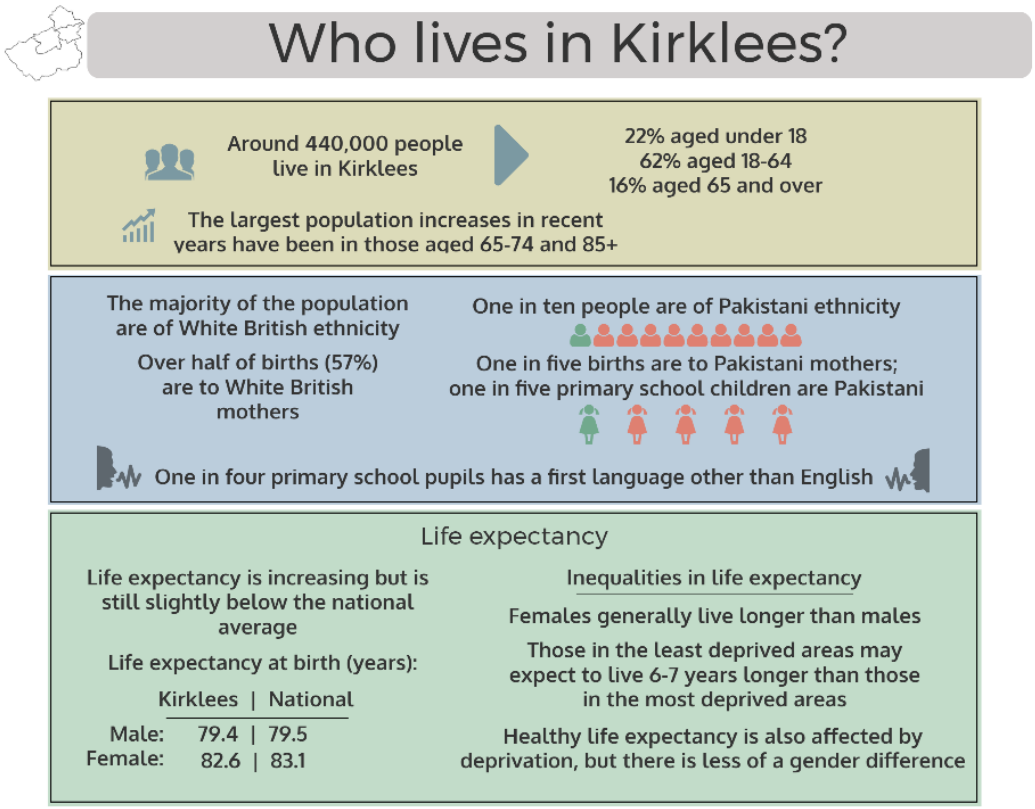
Our Population and Their Needs

The Health and Social Care Act (2012) requires the Health and Wellbeing Board, working through local authorities and CCGs, to produce a Joint Strategic Needs Assessment (JSNA) of the health and well-being of their local community. In Kirklees, an annual Kirklees Overview is published online following approval by the Board, and provides a useful context for more detailed sections of the Kirklees Joint Strategic Assessment (KJSA) by summarising the big issues and key challenges for

health and wellbeing. The latest version can be viewed at: http://observatory.kirklees.gov.uk/Custom/Resources/Kirklees_Overview_2021_PDF.pdf.

In summary:

- Around 440,000 people live in Kirklees
- The population has increased by 8.4% since 2002, and is predicted to rise by a further 9.9% by 2030
- Projected increases are largest in very young and older adult age groups
- Over three-quarters of the population are of White British ethnicity
- One in ten people and one in five primary school children are of Pakistani ethnicity
- Life expectancy is increasing but there are inequalities – those in the least deprived areas live longer than those in more deprived areas
- Demand for suitable and affordable accommodation outstrips supply
- The number of households is expected to increase by 20% by 2039
- Around one in five people work in manufacturing (more than double the rate for England)
- More than two thirds of workers live and work in Kirklees
- Although fertility rates are declining, they are still higher than the England average
- Infant mortality rates have almost halved in the last 10 years, but are still amongst the highest in the region
- Mortality rates for under 75-year-olds are higher than national averages for cardiovascular and respiratory disease
- Asylum seekers and European economic migrants are contributing to the emergence of new communities within Kirklees



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, following engagement with CCG members, our staff and patients.

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 Greater Huddersfield and North Kirklees CCGs' Operational Plan set out our ambitions for delivering high quality, financially sustainable services in the future and outlined how we planned to address the objectives described in the NHS England Long Term Plan during 2020-21. The plan underpins delivery of the Kirklees Health and Wellbeing Plan which is the local delivery vehicle of the West Yorkshire and Harrogate Integrated Care System (WY&H ICS).

The NHS is operating in an increasingly challenging environment, striving to maintain the availability of high quality services which respond to increased demand from a growing, aging population, and the availability of new and more innovative technology within the restraint of less resource. This is something we and other organisations are experiencing locally and we will be continuing actively to progress measures to recover and bring stability to the system over the next years. We will continue to re-focus our efforts on achieving the best outcomes for our population with the limited resources we have available to us. We will increase our focus on prevention and commission services which deliver proactive as well as reactive care. We will also empower patients to take responsibility for their own care and support changing behaviour through care planning and self-care initiatives.

Working with partners, patients and the public to look for opportunities to work at scale and in different and more integrated ways to secure sustainability for the future is at the forefront of this work. The development of a joint operational plan for Greater Huddersfield and North Kirklees CCGs signals our commitment to taking this work forwards. The existing plans for both CCGs have been refreshed to reflect the priorities and deliverables for 2020-21.

A key driver of integration is the development of joint commissioning plans and functions across the CCGs and Kirklees Council for transformation which is undertaken over a 'Kirklees Place' footprint and transformation undertaken over an

‘Acute System’ footprint with neighbouring Wakefield and Calderdale CCGs. This is supported by providers coming together to deliver services as a collaboration.

In 2016-17 Organisations (Provider, Commissioner and Local Authorities) were given a mandate to collaborate over an agreed geography (footprint) and develop plans which would address local challenges across the three gaps in the NHS England, *Five Year Forward View*. Our local STP footprint is West Yorkshire and Harrogate and changes are being delivered at this level through the West Yorkshire and Harrogate Integrated Care System (WY&H ICS).

The WY&H ICS exists to improve outcomes for people locally therefore its success is built on local relationships ‘Places’ to ensure change addresses local need and can happen as close to people as possible. By planning and working across a bigger footprint there is an opportunity to improve outcomes at a local level through sharing good practice and resources and learning from each other.

The priorities within the WY&H ICS are driven by those identified within ‘Places’. The CCGs are active members of the Kirklees Place. The Kirklees Health and Wellbeing Plan was developed to identify the priorities within Kirklees which drives what we have agreed to work together on through the WY&H ICS. The WY&H ICS has identified nine priorities and six enabling work streams. There also is an additional work stream focussing on carers.

Kirklees is one of seven national ‘**pilot**’ sites receiving a share of a £14 million national investment. The funding is part of a commitment set out in the NHS Long Term Plan to help keep older people well at home and reduce pressure on hospital services.

Kirklees have developed a community-based urgent care service for some of the most vulnerable patients, including those who are frail, elderly or have multiple long-term conditions.

The local NHS, council and community service teams have worked together to develop the service, which will ensure urgent health and social care support is available within two hours to help the elderly and those with complex needs remain well at home and avoid hospital admissions.

The service also ensures people receive tailored packages of care designed to restore independence and confidence after a hospital stay, within two days.

The WY&H ICS has recently been named as one of four new areas in England that will be given additional freedom and flexibility to manage the delivery of local services. The Partnership will join the Integrated Care System programme, putting the area at the forefront of nationwide action to provide better co-ordinated and more joined up care.

Primary Care

Our Primary Care Strategy aims to:

- Enable patients to be able to make appropriate choices and responsible decisions about their health and wellbeing;
- Provide easily accessible primary care services for all patients;
- Ensure consistent, high quality, effective, safe, resilient care delivered to all patients;
- Develop a strong, innovative and resilient multidisciplinary workforce in primary care which recognises the difficulties in recruiting, retaining and training clinicians;
- Improve use of modern technology;
- Provide education and training opportunities that cultivate professional excellence and high motivation;
- Improve premises and infrastructure which increases capacity for clinical services out of hospital and improve 7 day access to effective care;
- Provide effective contracting models which are fairly and properly funded to deliver integration and positive health outcomes;
- Develop a culture which promotes openness and transparency;
- Ensure General Practice is at the heart of the health and social care system working collectively with partners and the wider community;
- Work at scale in General Practice through collaboration with partners.
- Ensure all Primary Care Networks (PCNs) meet national and local requirement in their development and further establishment across the system, improving integration and coordination across primary care providers.

Right Care, Right Time, Right Place

The Strategic Outline Case for capital expenditure of £196.5 million to support implementation of the plans to reconfigure hospital services was submitted by Calderdale & Huddersfield Foundation Trust (CHFT) to NHS England and NHS Improvement in April 2019 and approved in November 2019. The public and colleague involvement work to develop the 'Design Brief' that describes the principles which inform and support the development of detailed design and construction schemes at both Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) was concluded prior to the Covid-19 pandemic and is available on the CHFT website.

Local people, key stakeholders and the Joint Health Scrutiny Committee continue to be fully involved in the next steps to deliver the proposed future model for hospital services across Calderdale and Greater Huddersfield. Since the development of the

design brief the COVID-19 pandemic has necessitated many service changes forced by critical need and implemented at pace across the health and social care system. The findings from the pandemic will build on the design brief previously developed to incorporate opportunities for improvement and accelerated transformation in some areas. This will also ensure that further design elements that take account of best practice in building design regarding infection control and prevention are included.

The continued work to progress the design plans at CRH and HRI will be incorporated into an updated Design Brief for each site. The updated Design Briefs will include drawings and visualisations of the proposed builds and narrative that addresses key issues related to wider impact on factors such as: conservation, ecology, heritage, social value of the development, air quality, and sustainability. The Design Briefs are key documents to support the submission of the planning applications to Calderdale Council and Kirklees Council.

In March 2021, ahead of the submission of the formal planning applications to the Councils, the Trust commenced involvement of key stakeholders and local residents to explain the design and building plans and provide opportunity for comment.

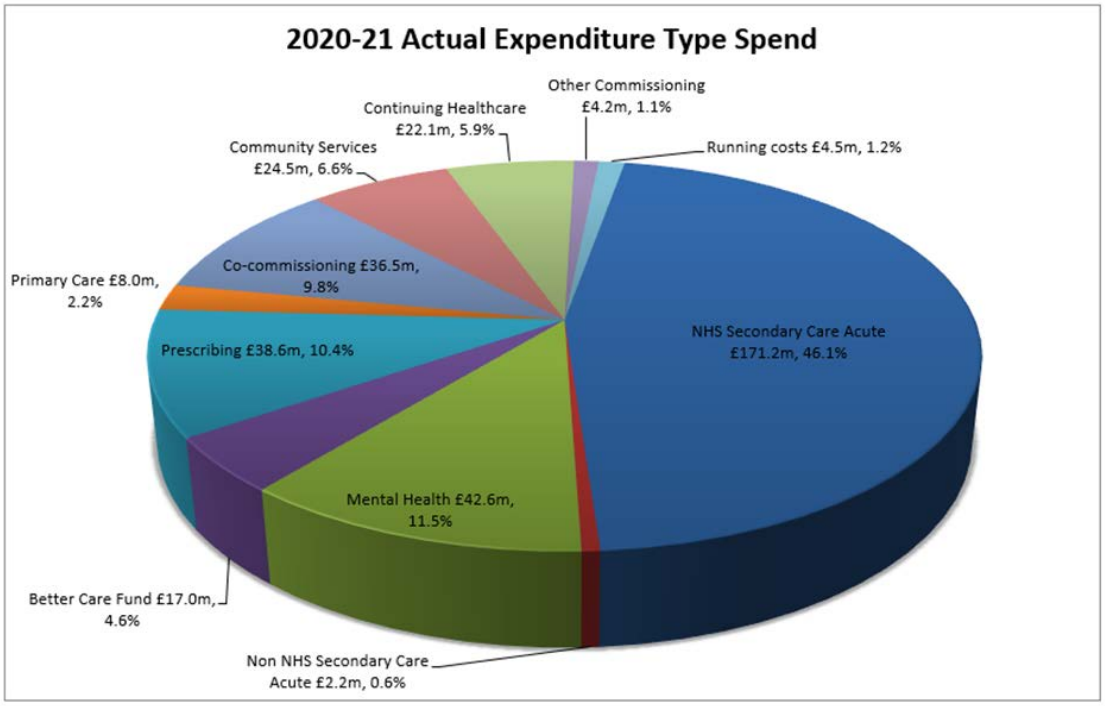
The detailed design and appearance of the proposals at CRH and HRI has not yet been confirmed. Public input will be considered alongside other partners / stakeholders and statutory consultees and will be used to inform the design development discussions at this stage of the process and will also play a key part in the detailed design development at future stages. Feedback on the design of the proposals will be used to inform the final designs in a 'Design and Access Statement', which will be submitted with the planning applications. The planned date for submission of planning applications to Calderdale and Kirklees Councils is May 2021.

The timescale for the development and submission of future business cases has been adjusted to take account of the fact that the estate at HRI carries a high risk in relation to the condition and reliability of the existing buildings. It has therefore been agreed with NHSE and DHSC that to enable the commencement of estate improvement work as early as possible a Full Business Case for the investment at HRI will be developed and submitted for approval by NHSE and DHSC in 2021. For the investment at CRH an Outline Business Case will developed and submitted in 2021 and subject to NHSE and DHSC approval a subsequent Full Business Case will be developed for approval by 2023.

How we spend your money

Due to the Covid-19 pandemic, the CCG has received funds via a new NHS England financial framework that was introduced to support the health and social care system at the start of the year. As a result of this the CCG did not receive funding via a population-based allocation basis for 2020-21. For 2020-21, the CCG has received funds to support business as usual activity via an allocation/claim process but has

also received additional funds to cover costs to the support the pandemic during the year. Due to the impact of Covid-19, there has been several significant changes to how we pay for services and contracts during the year. For 2020-21, contracts for the Independent Sector have been procured centrally by NHS England and our main providers of secondary care services have been paid agreed monthly payments to support services and income during this period. These changes allowed a reduction in the administration burden for the health care system. As a result of these changes how the CCG has spent funds has slightly differed from previous years as it will not include some expenditure paid in the past and will include additional costs to support the pandemic. The split for the year is shown in the graph and table below. Overall, the CCG has committed £371.375m for the financial year 2020-21.



2020-21 Actual Expenditure Type Spend

Expenditure Type	£,000	%
NHS Secondary Care Acute £171.2m	171,157	46.1%
Non NHS Secondary Care Acute £2.2m	2,209	0.6%
Mental Health £42.6m	42,571	11.5%
Better Care Fund £17.0m	16,958	4.6%
Prescribing £38.6m	38,613	10.4%
Primary Care £8.0m	8,042	2.2%
Co-commissioning £36.5m	36,537	9.8%
Community Services £24.5m	24,538	6.6%
Continuing Healthcare £22.1m	22,057	5.9%
Other Commissioning £4.2m	4,226	1.1%
Running costs £4.5m	4,466	1.2%
Total 2020-21 Expenditure	371,375	100.0%

Key Issues and Risks

The CCG's principal risks are set out within the Governing Body 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. There is further detail within the Governance Statement on the CCG's approach to controlling and mitigating 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 Governing Body 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 workforce to deliver a sustainable and effective General Practice – e.g. GPs, nurses and practice managers - due to the inability to recruit and train a local workforce 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 benefit of the funding spent in Greater Huddersfield i.e. not delivering value for money.

- There is a risk that we are unable to secure active participation particularly from Member Practices resulting in the CCG's ability 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.
- There is a risk that not using the wider determinants of health (eg JSA, HWBS) effectively will result in ineffective initiatives to improve the lives of everyone in Kirklees.

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 of not commissioning appropriate alternatives to hospital care resulting in services continuing to be accessed in hospital.

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 enduring mental ill health and/or learning disability issues will have inequitable access to services to enable them to maintain their 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.
- There is a risk that we are unable to establish and support the development of strong Primary Care Networks resulting in inequities in service delivery.

- There is a risk to the delivery of sustainable Primary Care services if the following threat(s) are not successfully managed and mitigated by the CCG:
  - Engagement with Primary Care Networks
  - Workforce and capacity shortage, recruitment and retention
  - Under development of opportunities of primary care at scale
  - Increasing pressure and demand on services leading to workload pressures
  - Inadequate investment in primary care and primary care infrastructure

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.
- 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 integrate to meet the needs of patients at or as close to home as possible.

Strategic Objective 9 – Deliver our financial plans

- There is a risk of failure to meet financial statutory responsibilities due to failure to meet financial targets, resulting in reputational risk, endangering patients and primary care services.

Strategic Objective 10 - Invest in the health, well-being and personal development of our staff.

- There is a risk that failure to attract and maintain an adequate workforce and maintain high morale will result in a lack of capacity to deliver the CCG's business requirements.

Corporate risks not directly linked to a strategic objective.

- There is a risk of failing to deliver annual accounts in the required timescale, to the required professional standard and supported by sound systems and processes, resulting in failing to meet key NHSE requirements and reputational damage.
- There is a risk that failure to manage conflicts of interest properly will result in unsafe decision making.
- There is a risk of a breach of statutory duties/regulations, due to inadequate adherence to principles of good governance and our legal framework, resulting in reputational or financial damage, or risk to patients and services.
- There is a risk that failure to meet the NHS performance standards will result in reputational risk and endanger patients and services.

Moving Forward - Our Financial Plan for 2021-22 – Kirklees CCG

The CCG from the 31 March 2021 ceased to exist and has successfully merged to become the new NHS Kirklees CCG from the 1st April 2021. The CCGs' merger will

allow the Kirklees system to continue and develop services on a much wider footprint and develop greater economies of scale of resources that will ensure that all the population of Kirklees has access to the same level of services moving forward.

However, it should be recognised due to the ongoing impact of Covid-19 the new CCG will see a continuation of the financial framework that started this year. The CCG is currently developing merged financial plans for the first six months of the financial year and will have a new financial target to achieve a breakeven for 2021-22.

The CCG as part of this initial six-month plan is also looking at the full year implications of its overall expenditure plans and investments as we start moving into a more recovery phase of the pandemic. The combined CCGs pre and during Covid-19 had started and continued to work on improving its overall financial positions and will have a combined cumulative carried forward position of £2.9m. As we work through the year the new combined CCG will carry on this momentum to improve its overall financial position and on-going trajectories.

Whilst the plan is anticipated to achieve the breakeven financial target, the forthcoming year will not be without challenges. The new year due to the impact of Covid-19 on the health care system will require on going work to support the recovery of patient backlogs that have arisen due to the pandemic and the CCG will need to consider the long-term impact on the population in areas such as Mental Health and the unknown impact of long-Covid. Also, as part of the pandemic the inequalities in the health provision in some areas has been further highlighted.

Therefore, the plan that is being developed will incorporate the following areas –

- Supporting areas that have been greatly impacted by Covid
- Reduce the back logs of patient activity – working closely with provider colleagues
- Target the impact of health inequalities in the system
- Continuation of developing out of hospital services with local partners, to ensure care can be provided in the community settings
- Continued focus on delivery of financial targets and ensuring delivery of any efficiency targets
- Ensure that we spend our funding allocation to deliver the best outcomes for patients
- Continue to adopt a collaborative approach with partners to ensure that resources are deployed effectively.

Performance Summary

The Annual Report 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. The impact of COVID over the last twelve months has had a significant impact on performance across all measures but is most noticeable on the referral to treatment targets, waiting times and diagnostic measures. All three of these measures have seen significant deterioration in line with the performance that we are seeing nationally.

Demand on our hospital services continues to be significant and although numbers of A&E attendances are down by 28,710 and 4 hour breaches are down by 5,218 at CHFT challenges still remain. Our health economy has experienced a number of issues, not least for the elective care system and the impact of COVID on waiting times, notably the delays relating to Referral to Treatment (RTT) and those patients waiting in excess of 52 weeks.

Greater Huddersfield CCG, Calderdale CCG and Calderdale and Huddersfield NHS Foundation Trust formed the Accident and Emergency Delivery Board (A&EDB) in 2017, this forum continues to provide an opportunity for all Health and Social Care partners to address system pressures through an integrated approach. Key partners from both the Health and Social Care economy continue meet monthly to discuss the current issues and agree actions to address any areas of underperformance.

The last twelve months have been exceptional with the system response to COVID creating new challenges and intense pressure on clinical services. The response to managing the outbreak as well as the co-operative working to facilitate the roll out of the national vaccination program at the local (Kirklees) level has been excellent.

The emergency care standard (ECS) of 4 hours has continued to be under great pressure in spite of the reduction in numbers of patients presenting. The reported performance for 2020-2021 is 88.8% for Calderdale and Huddersfield NHS Foundation Trust. This shows a small improvement of 1.3% from the previous year.

CHFT are participating in the Elective CRS pilot so will not be reporting performance against the 18 week standard. Greater Huddersfield CCG has however tracked performance in this area and has excluded CHFT performance in line with the requirements of the pilot. The year to date figure for Greater Huddersfield patients excluding those attending CHFT is 67.9%. COVID has also had a significant impact on patients waiting 52 weeks and the year to date figure for Greater Huddersfield is 4746 patients.

Performance against the cancer measures for the CCG and in partnership with the trust is much better with only two of the national measures not achieving target:

- Maximum 31-day wait for subsequent treatment where that treatment is surgery (85.9%/94%)

- Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers (61%/90% - very low numbers)

The remaining 6 reportable cancer standards are all being achieved.

Based on the strong and consistent levels of performance we have achieved with our partners at CHFT in this area, we have been recognised as a high performing system by the WY&H Cancer Alliance. This achievement relies on strong partnership working combined with rigorous management and oversight of the pathway. In recognition of this, the Alliance has asked colleagues from our system to work with their core team and act as a critical friend to other organisations in WY&H in reviewing pathways and recovery plans based on our track record of delivery. In support of the system, and in spite of the current pressures, CHFT staff visited Airedale NHS Foundation Trust to provide support and a constructive review of their processes and procedures relating to their cancer pathways. A number of suggestions were made and the trust has adopted recommendations made.

This recognition puts Huddersfield in an excellent position to support the requirements of the NHS Long Term Plan with the ambitions to improve early cancer diagnosis and accelerating access to diagnosis and treatment.

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

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 Performance Analysis section was optional in 2020-21 due to the significant impact on resources due to the ongoing Covid-19 pandemic response. The CCG has aimed to include as much of the usual Performance Analysis section as possible, and has ensured the statutory requirements are met.

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.

CCG Improvement and Assessment

Clinical commissioning groups (CCGs) were established on 1 April 2013 and are clinically-led organisations at the heart of the NHS system. NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. NHS England did this through implementing the CCG Improvement and Assessment Framework (IAF), and since April 2019 the Oversight Framework.

Oversight Framework 2020-21

The CCG Improvement and Assessment Framework (IAF) was updated for 2019-20, and replaced by the Oversight Framework which came into effect in April 2019, with updated metrics, the removal of some measures and the retention of the majority of the previously reported Improvement and Assessment measures. It builds on the IAF introduced in April 2016, which replaced both the existing CCG assurance framework and CCG performance dashboard, and was designed to provide a greater focus on assisting improvement, alongside the statutory assessment function.

The Oversight Framework aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

The framework is intended as a focal point for joint work and support between NHS England and CCGs. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the Five Year Forward View (FYFW).

How the CCG Measures Performance

In order to measure how well the CCG is performing against the NHS Constitutional standards, and the indicators set out in the Oversight Framework, a monthly performance report is produced showing the current month's performance against each of the Constitutional Standard metrics as well as the year to date position. Oversight framework metrics are reported on a quarterly basis. 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, Performance and Contracting 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 and national and local priorities identified in the Outcomes Framework.

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; however, several of the commissioner roles are shared posts between the Calderdale and Greater Huddersfield CCGs. 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, Performance & Contracting 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 framework is intended as a focal point for joint work, support and dialogue between NHS England, CCGs, and STPs. Data is available at least quarterly for nearly all of the indicators, which enables everyone to see, in-year, what is working well and what is off-track. NHS England's national and regional teams are working together to ensure that the breadth of the framework is discussed with all CCGs during the year, through a rolling programme of local conversations, drawing on expertise and insight from the national programme teams.

The CCG assurance arrangements for 2020-21 saw the introduction of a new model of **integrated whole place assurance** for partners in WY&H. This saw all partners across Kirklees Health and Social Care footprint coming together to offer assurance against key priorities and national targets. The new arrangements were agreed by

the System Oversight and Assurance Group in January 2020. This is a key element of the development of our mutual accountability framework. The performance management regime during the year focussed on:

- Whole place quarterly review meetings with ICS and NHSE/I
- Formal annual assessment of CCGs by NHSE informed by the ICS
- NHSE/I and ICS agree where escalation or enhanced oversight is required
- NHSE/I will work with ICS to determine and coordinate a tailored support package, based on segmentation of support needs.

Key Purposes of New Framework

- To support the alignment of the priorities of places, and the partner organisations within them.
- To help identify where places/organisations need support to improve.
- To provide an objective basis for decisions about when and how to use formal regulatory powers of intervention in cases where there are serious problems or risks.

Scope of New Framework

- Clear focus on transformation, improvement and collaboration.
- Built around the priorities and indicators of the place plans.
- Focus on both immediate and longer term priorities, such as health outcomes and inequalities.
- Underpinned by regular review meetings, involving leaders from all partners in each place

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.

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 the 92% target rate has not been met for the 18 week standard for incomplete pathways across 2020-21. The year-end performance for 2020-21 was 69.1%, but this data excludes CHFT (CHFT excluded since August 2019) as they are participating in the Elective care pilot and their data is excluded.

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 2020-21, Greater Huddersfield CCG reported that 2592 residents had waited 52 weeks or more. Please note the total number of 52 week waits was calculated using the incomplete and completed 52 week cases to account for the number of patients that remained on the waiting list beyond the point at which they first breached 52 weeks. A robust reporting mechanism has been introduced to get an early warning of potential breaches, allowing a timely conversation between providers and commissioner to prevent further breaches.

Compared to the same time last year, this figure is significantly higher due to the effect of Covid-19 on waiting times as hospitals face unprecedented pressures. The charts below show the comparison of waiting times between this and last year, benchmarking against neighbouring CCGs.

Figure 1 52 Week Waits 2019-20

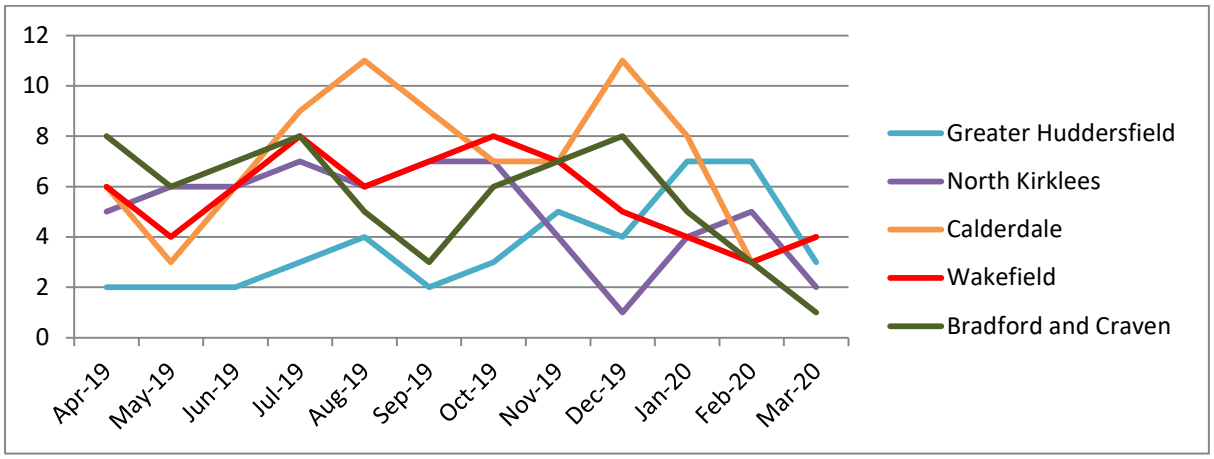
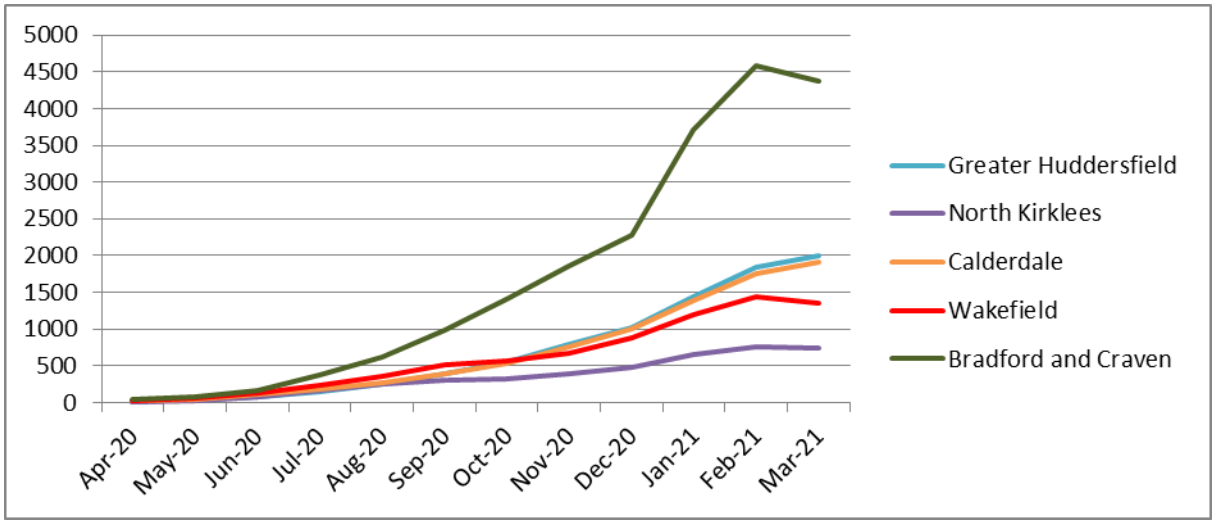


Figure 2 52 Week Waits 2020-21



In 2019-20 on average 3.6 Greater Huddersfield CCG patients waited more than 52 weeks for treatment, compared to 5.0 in North Kirklees CCG, 7.0 in Calderdale CCG, 5.7 in Wakefield CCG and 5.6 in Bradford and Craven CCG.

In 2020-21 all areas saw the effect of Covid-19 on their waiting times with an increased number of patients across the area waiting more than 52 weeks for treatment. On average in 2020-21 714.9 Greater Huddersfield CCG patients waited more than 52 weeks for treatment, compared to 348.8 patients in North Kirklees CCG, 699.8 patients in Calderdale CCG, 619.7 patients in Wakefield CCG and 1707.6 in Bradford and Craven CCG.

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 2020-21 was 55.5% of patients waiting 6 weeks or more for a diagnostic test. At the same time last year, 6.7% of patients were waiting 6 weeks or more.

The effect of Covid-19 has greatly increased wait times for Greater Huddersfield CCG and neighbouring CCGs as the charts below show when we compare 2019-20 to 2020-21.

Figure 3 Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral - CCG % 2019-20

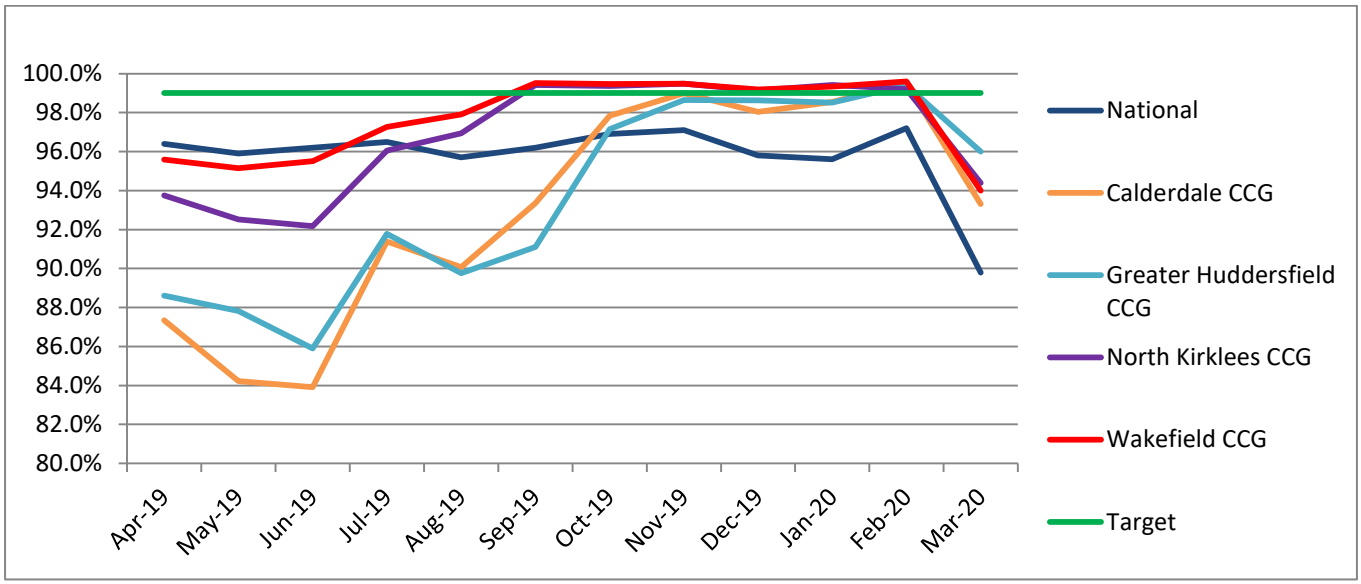
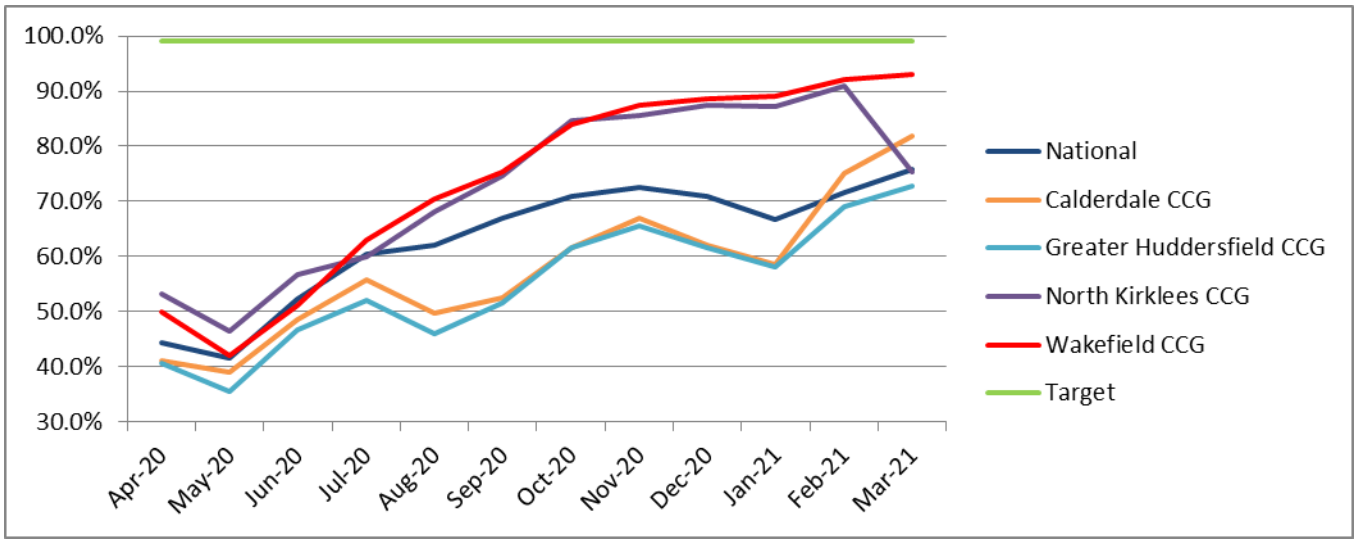


Figure 4 Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral - CCG % 2020-21



In 2019-20 Greater Huddersfield CCG performed lower than the national average in the first half of the year, gradually increasing over the winter period. Covid-19 had a dramatic impact on waiting times from March 20 to April 20 with Greater Huddersfield CCG increasing from just 4.0% of patients waiting over 6 weeks from referral in March 20 to 59.5% of patients waiting over 6 weeks in April 2020. The proportion of patients waiting over 6 weeks has steadily decreased over 2020-21, improving to 27.3%, however Greater Huddersfield CCG remains lower than the national average and below its regional neighbours

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.

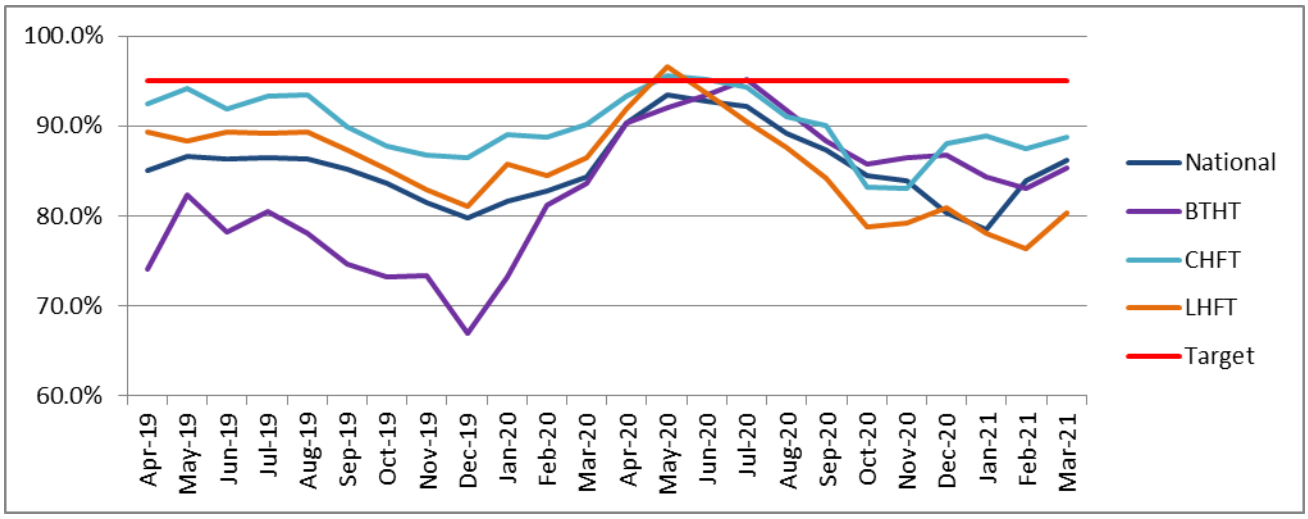
Longer lengths of stay are associated with poorer health outcomes and patient experience, as well as transport delays, treatment delays, ambulance diversion, patients leaving without being seen and financial effects. It is critical that patients receive the care they need in a timely fashion so that 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.

The Accident & Emergency Delivery Board continue to meet monthly to discuss system pressures. This is made up of representatives from across health and social care and covers our acute footprint of Calderdale & Huddersfield NHS Foundation Trust.

Calderdale and Huddersfield Foundation Trust achieved 88.9% in 2020-21. Performance has deteriorated this year in line with National trends and the continuing increases in both the number of attendees and the acuity of the patients presenting at A&E. YTD at March 2021 CHFT had 125,419 A&E attendances with 14,067 patients waiting in excess of the 4 hour standard. Throughout the course of 2019-20 and 2020-21 CHFT has tracked slightly higher than the national average as the chart below shows:

Figure 5 Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department * - Trust %



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 2020-21 MSA reporting has been suspended due to Covid-19.

Cancer waits – 14 days

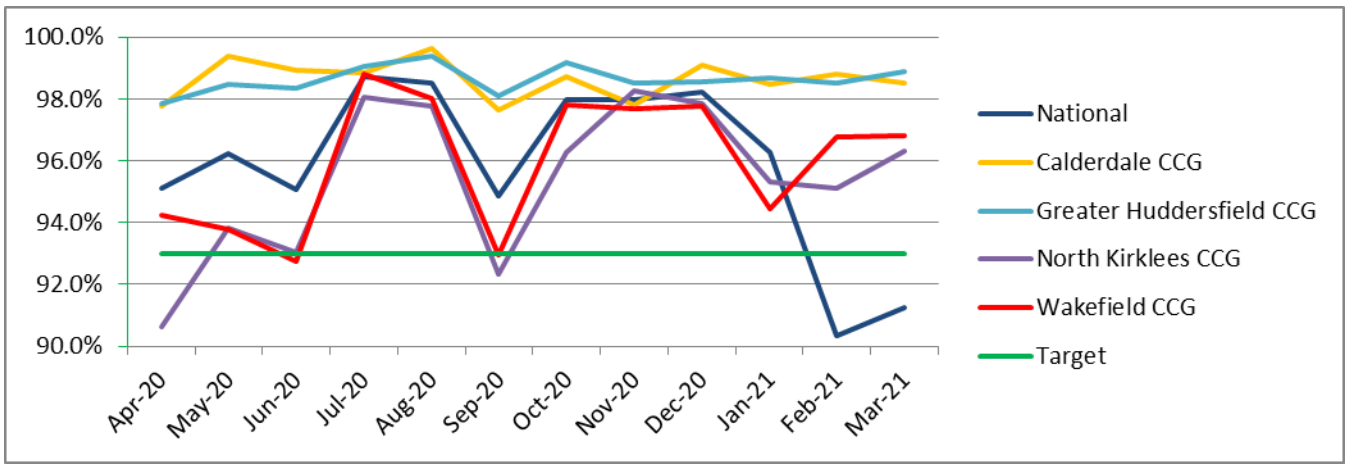
The NHS Constitution states that patients should have a maximum two-week wait for their first outpatient appointment if referred urgently with suspected cancer by a GP. It also states that patients should have a maximum two-week wait for their first outpatient appointment if referred urgently with breast 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 2020-21 for Greater Huddersfield CCG was:

- All cancer two-week waits – 98.7%
- Two-week wait for breast symptoms – 97.4%

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. Despite the impact of Covid-19 on all trusts, the CCG has performed above the standard of 93% and has been the highest performing CCG in our locality 7 out of 12 months.

Figure 6 Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP % - CCG 2020-21



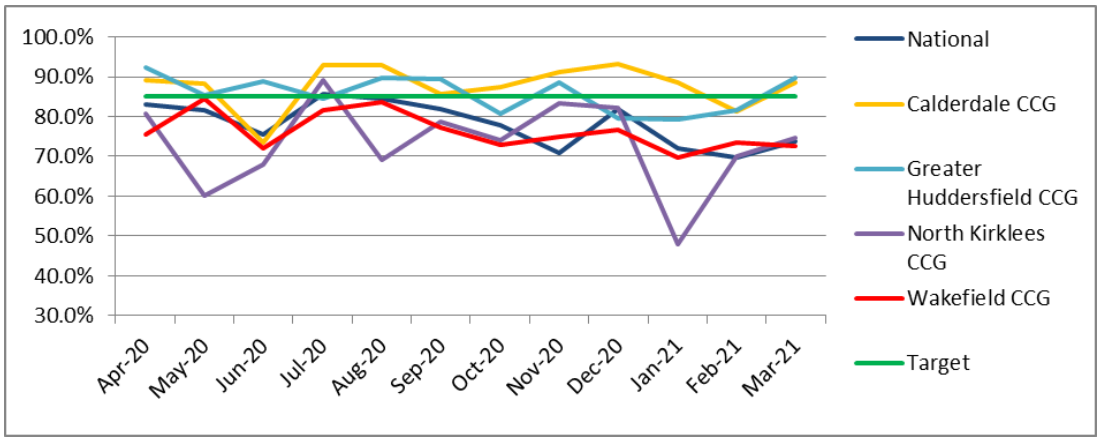
Cancer waits – 31 and 62 days

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 CCG 2020-21 year end performance is:

- Maximum one month (31 day) wait from diagnosis to first definitive treatment for all cancers – 96% (CCG performance – 96.8%)
- Maximum 31 day wait for subsequent treatment where that treatment is surgery – 94% (CCG performance – 86.3%)
- Maximum 31 days wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98% (CCG performance – 99.3%)
- Maximum 31 day wait for subsequent treatment where the treatment is a course of radiotherapy – 94% (CCG performance – 98.3%)
- Maximum two month (62 day) wait from urgent GP referral to first definitive treatment for cancer – 85% (CCG performance – 86.3%)
- Maximum 62 day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90% (CCG performance – 67.9%)
- 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 – 72.7%)

Performance is strong but can be greatly impacted by minimum breaches due to the low number of patients on the pathway. All breaches have a root cause analysis undertaken and breach reasons are monitored monthly. The chart below shows how the CCG has performed across 2020-21 performing largely above or to target in the first 6 months, however seeing a drop in the later few months of the year, in line with other CCGs in the region and the national average.

Figure 7 Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer % - CCG 2020-21



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 have been three reported cases of MRSA for Greater Huddersfield residents. 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 Committee and action plans agreed to monitor performance throughout the year are scrutinised by the Quality Team. Although there is a zero tolerance standard, this figure remains low when compared to other trusts across the region.

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

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 2020-21 annual CDI objectives for the CCG were set at no more than 39 cases. The CCG is required to establish and report against monthly trajectories for CDI cases in order to ensure continued reduction.

There have been 56 reported cases in respect of Greater Huddersfield CCG residents in 2020-21. 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 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 2020-21 Cancelled Operations reporting has been suspended due to Covid-19.

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. In 2020-21 CPA reporting has been suspended due to Covid-19.

Calderdale and Huddersfield NHS Foundation Trust (CHFT) Performance

CHFT are participating in the Elective CRS pilot so will not be reporting performance against the 18 week standard. More details will be provided as they are available. Initial indications are that it will be measured against average waiting time and the benchmark is being defined. The pilot commenced on 1st August and was initially expected to run until November 2019, the latest update suggests the pilot is on-going as at March 2021.

Calderdale and Huddersfield Foundation Trust achieved 88.8% against the target of 95% for the 4 hour emergency standard in 2020-21. Performance has deteriorated this year in line with National trends despite the impact of Covid-19 seeing a reduction of the number of people attending A&E.

CHFT reported 36 waits from decision to admit to admission (trolley waits) of more than 12 hours in the 2020-21 period, compared to just 9 in the previous year.

The trust achieved ALL Cancer waiting times standards in 2020-21. Performance was one of the best in our locality.

Figure 8 Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP % - Trusts 2020-21

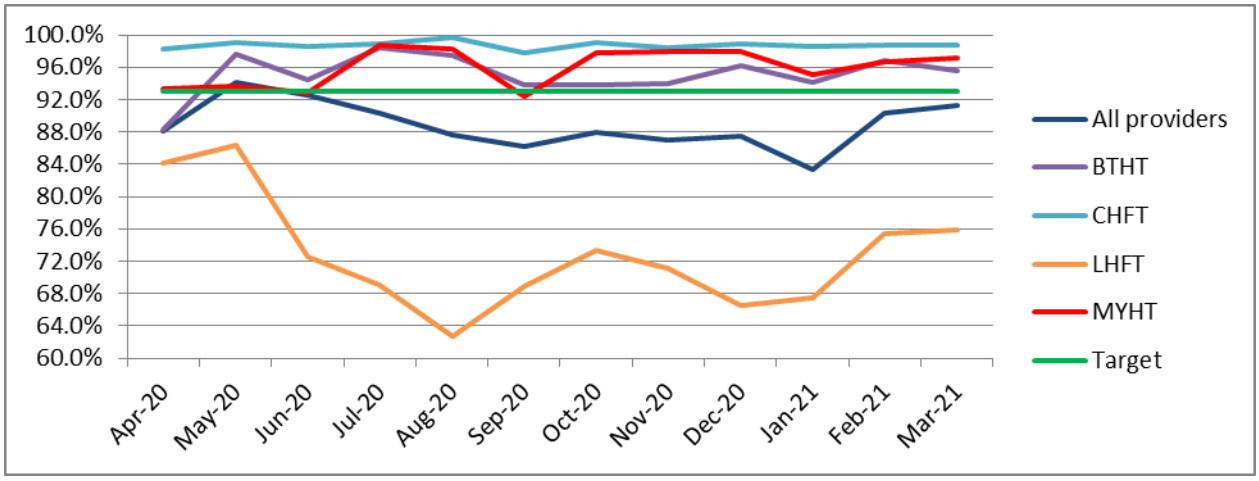


Figure 9 Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms % - Trusts 2020-21

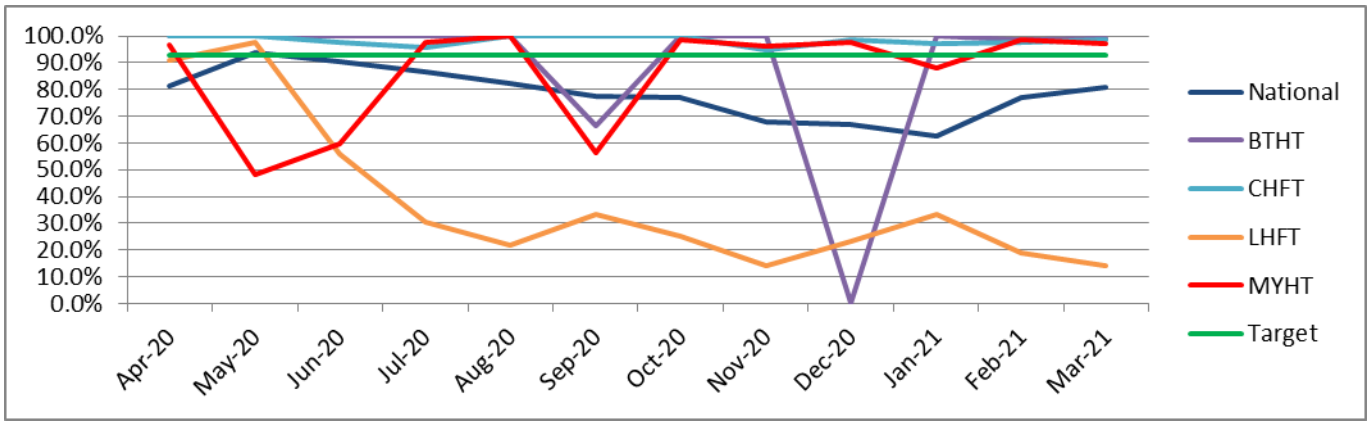


Figure 10 Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers %- Trusts 2020-21

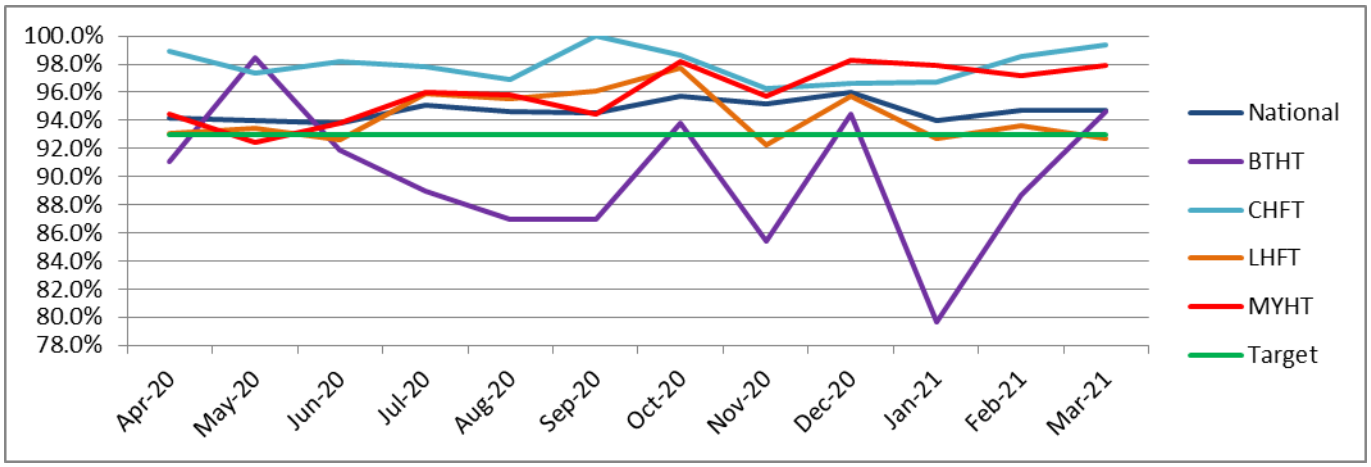
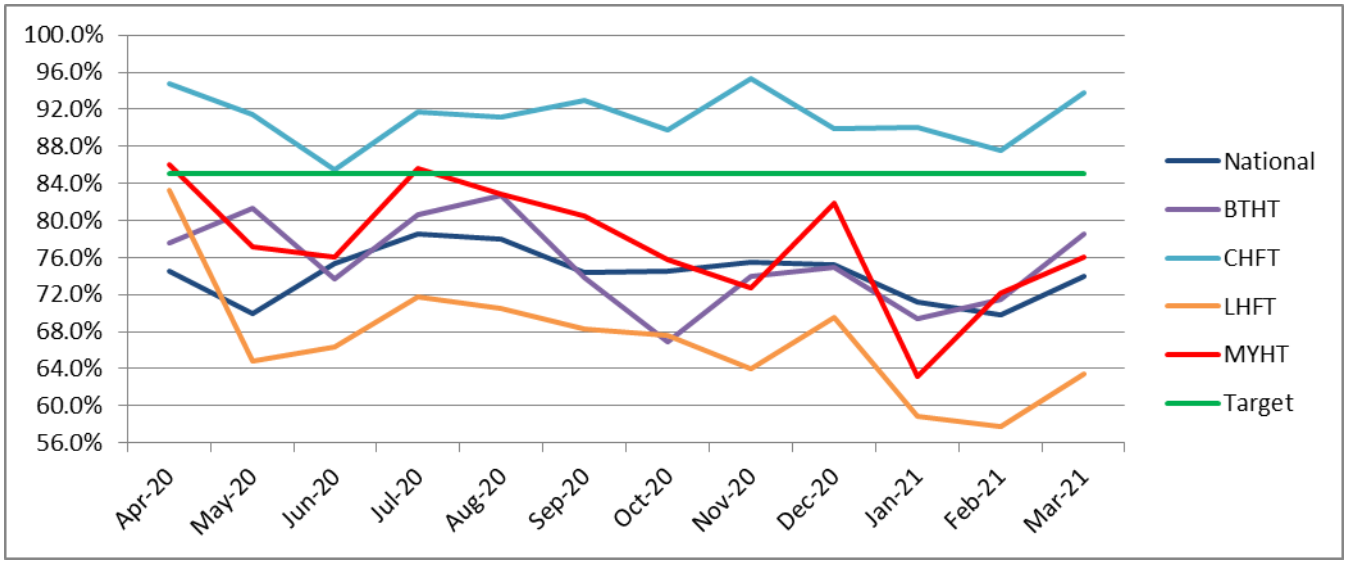


Figure 11 Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer % - Trusts 2020-21



In relation to 62 day cancer access standards have been a key element of the NHS's approach to improving the timeliness of treatment for people with cancer since they were introduced in the NHS Cancer Plan in 2000. One of the key indicators to assess progress is the time it takes for a patient to receive treatment they need - which follows the whole patient pathway from GP referral to their receipt of treatment.

Based on the strong and consistent levels of performance achieved at CHFT in this area, we have been recognised as a high performing system by the WY&H Cancer Alliance. This achievement relies on strong partnership working combined with rigorous management and oversight of the pathway. In recognition of this, the Alliance has asked colleagues from our system to work with their core team and act as a critical friend to other organisations in WY&H in reviewing pathways and recovery plans based on our track record of delivery. This builds on our collaborative approach to improvement with an openness to learn from each other about what works in what environment and 'stress test' each other's plans and business cases.

NHS Constitution Rights and Pledges 2020-21

The dashboard that follows shows performance against all NHS constitutional measures, for both the current month and year to date.

Reporting Period March 21	Measure	Target / Baseline	Period Actual	Period RAG	YTD	YTD RAG
Referral To Treatment waiting times for non-urgent consultant-led treatment	Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 wks from referral (EXCL - CHFT)	92%	75.4%		69.1%	
Referral To Treatment waiting times for non-urgent consultant-led treatment	Patients on incomplete pathways waiting more than 52 weeks	0	1998		2592	
Diagnostic Test Waiting Times	Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral	99%	87.8%		55.5%	
A&E Waits	Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&E department	95%	86.4%		88.8%	
A&E Waits	No waits from decision to admit to admission (trolley waits) of more than 12 hrs	0	0		36	

Reporting Period March 21	Measure	Target / Baseline	Period Actual	Period RAG	YTD	YTD RAG
Cancer Waits - 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP	93%	98.9%		98.8%	
Cancer Waits - 2 week wait	Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer not initially suspected)	93%	98.1%		97.4%	
Cancer Waits - 31 days	Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers	96%	97.9%		96.8%	
Cancer Waits - 31 days	Maximum 31-day wait for subsequent treatment where that treatment is surgery	94%	96.0%		86.3%	
Cancer Waits - 31 days	Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen	98%	100%		99.3%	
Cancer Waits - 31 days	Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy	94%	100%		98.3%	
Cancer Waits - 62 days	Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer	85%	89.7%		86.3%	
Cancer Waits - 62 days	Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers	90%	100.0%		67.9%	
Cancer Waits - 62 days	Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)	tba	100%	TBC	72.7%	TBC
Ambulance Calls	All handovers between ambulance and A&E must take place within 15 minutes * CHFT	95%	67.4%		73.2%	
Ambulance Calls	All crews should be ready to accept new calls within a further 15 minutes * CHFT	95%	43.9%		46.2%	

Reporting Period March 21	Measure	Target / Baseline	Period Actual	Period RAG	YTD	YTD RAG
Mixed Sex Accomodation	Minimise breaches - reporting suspended COVID 19	0	0		0	
MRSA	Number of MRSA reported infections	0	0		3	
C_Diff	Number of C_Diff reported infections	39	6		51	
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, or the patients treatment to be funded at the time and hospital of the patients choice reporting suspended COVID 19	0	tbc			
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 from psychiatric inpatient care during the period reporting suspended COVID 19	95%	tbc			

West Yorkshire and Harrogate Health and Care Partnership: stronger, better, healthier together

West Yorkshire and Harrogate is a large, complex system covering public, voluntary community and social enterprise organisations (VCSE). Collectively we support 2.7million people, including 260,000 unpaid carers. 23% (570,000) of the total West Yorkshire and Harrogate population are children and young people. We are proud to be home to 20% of people from minority ethnic groups, and have a sense of pride in the richness, heritage and diversity of our communities.

As a CCG we are proud to be part of West Yorkshire and Harrogate Health and Care Partnership. The Partnership belongs to us all.

Since the Partnership began in 2016, we have worked hard with our partners and communities to build the relationships needed to deliver better health, care and wellbeing support to people across West Yorkshire and Harrogate.

In doing so it has enabled us to create meaningful provider collaboratives, such as the West Yorkshire Association of Acute Trusts, the Mental Health, Learning Disabilities and Autism Committee in Common, and our Joint Committee of Clinical Commissioning Groups. Supported by our politically led and inclusive Partnership Board (established in 2018) and all our places (Bradford district and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield), we have focused on the strength of joint working to improve people's lives.

The way we work has led to genuine changes, for example in the delivery of the vaccine programme, hyper acute stroke units (the critical care people receive in the first 72 hours), vascular services, and assessment and treatment units for people with complex learning disabilities, eating disorder services and a new specialised child and adolescent mental health services being built - to name a few.

It has led to good practice being shared, for example our award winning 'Healthy Hearts' programme, where around 6,300 patients have had a change to a more effective statin and 2,400 people who are at risk of CVD have been offered a statin. In total an estimated 1200 people could avoid a heart attack or stroke in the next five to 10 years across the area.

Another important example is our work to tackle health inequalities whilst improving the lives of the poorest the fastest. COVID-19, with its disproportionate impact on those with the greatest challenges, including minority ethnic communities and colleagues, gives added urgency to this work and our recent commission on this topic focuses on real action, from housing and jobs to improved planning, representative leadership and improvements in mental health services.

The COVID-19 crisis has strengthened relationships and trust. Without this solid foundation, our handling of the pandemic would have been much poorer. Issues like maintaining personal protective equipment supply, coordinating testing, helping people who were shielding and mutual aid have been led by individuals working for the collective.

We have invested additional funding, over £2.5m in the VCSE to continue their essential work. This stretches to the delivery of care as equal partners, for example support for men's mental health as part of our suicide prevention strategy; the Grief and Loss Support Service and our staff Check-In campaign to help prevent staff suicide and our mental health and wellbeing hub for all colleagues.

This is underscored by the established ethical principles that underpin our work to help individual clinical decision makers and multidisciplinary teams have confidence and integrity during the pandemic and into the future.

Our Improving Population Health Management Annual Report (December 2020) sets out the collective difference we have made in the past 12months, including our ambitions to address climate change and housing for health. It also sets out actions for 2021, including violence reduction and the impact of childhood trauma. Just some of our big ambitions set out in our coproduced Five Year Plan.

Whilst the direct impacts of COVID-19 on health are recognised, it is important to acknowledge the economic and societal impacts associated with the long-term nature of the restrictions in West Yorkshire. Residents of West Yorkshire have been under a combination of national and local restrictions for all but two months since the end of March 2020 (accurate March 2021). The economic impact of COVID-19 across West Yorkshire and Harrogate has led to significant job losses and a recession which brings additional risks to the health of people.

The relationships we have with the West Yorkshire Combined Authority for the area's economic recovery plan, Health Education England, the Academic Health Science Network, med-tech and the skills sector, including universities, helps us to look at what we can do together to develop and grow our workforce and support people into better jobs via our People Board work.

As a proud and valued partner, we are pleased with the progress we have made. Together we are sharing and spreading good practice across the area, and ultimately saving more lives by improving people's health and wellbeing.

We know that more needs to be done to give everyone the very best start and every chance to live a long and healthy life. **Only by working together can we truly achieve this.**

You can find out more about the difference our Partnership is making here and also by visiting www.wyhpartnership.co.uk or follow @wyhpartnership on twitter to find out more or get involved.

Information on the West Yorkshire & Harrogate Joint Committee of CCGs can be found in the Governance Statement at page 66.

Primary Care

Primary Care and COVID-19

In 2020-21, primary care services in Greater Huddersfield were predominantly focussed on the response to the COVID-19 Pandemic and in the latter half of the year, the delivery of a successful COVID-19 Vaccination Programme.

In the early days of the pandemic, primary care services had to rapidly adapt their ways of working and implement a 'digital first' approach which saw the utilisation of video, online and telephone consultations become the safest way to deliver services to the majority of patients. This way of reaching patients and reducing footfall to GP premises kept staff and patients safe and has remained in place as a model of operating services for the whole year. There is an increasing emphasis on restoring access to enable face to face consultations and the importance of this was a theme in the 2020 Healthwatch survey of patient experience during the pandemic in Kirklees. Access is likely to remain a priority in the recovery phase following the most recent national lockdown.

There were a number of actions taken and services commissioned which enabled primary care to remain resilient and responsive during the pandemic.

COVID Clinical Assessment Service (CCAS)

In April 2020, the CCG worked with local practices, GP Federations and Primary Care Network (PCN) Clinical Directors to commission a COVID Clinical Assessment Service (CCAS) or 'hot site'. These clinics enabled patients with COVID symptoms who required face to face appointments to be seen safely and separately to other non-COVID patients.

The CCAS in Greater Huddersfield was located at Princess Royal Health Centre (Huddersfield) and operated by My Health Huddersfield operating in partnership and under CQC registration of Locala CIC. This site was mothballed in June 2020, with a room in Princess Royal still retained for COVID activity.

COVID Home Response Team (CoHoRT)

The Kirklees COVID Home Response Team (CoHoRT) service was established in April 2020 offering a same-day service for housebound patients that were symptomatic (or confirmed positive) for COVID-19 (or housebound patients within a household where someone was COVID-19 symptomatic or positive) and needed face-to-face support.

It was agreed that the CoHoRT services would be managed by the Kirklees GP Federations and would work alongside the CCAC operations. Running these services together enabled the safe provision of staffing, workload, equipment, PPE and clinical oversight/support.

Appointments and service hours flexed in response to demand, throughout 2020-21. Reduced service utilisation in recent months led to collaborative discussions with the Kirklees Urgent Community Response (UCR) Programme and from April 2021, the UCR programme will manage appropriate COVID positive patients through a dedicated number of appointments available on a daily basis.

COVID testing

Greater Huddersfield and North Kirklees CCGs were chosen to be the first pilot sites in the Department of Health and Social Care's (DHSC) National Swab Pilot. This new collaboration meant all patients that were referred into CCAC or CoHoRT would be offered a Kingfisher swab test. The pilot commenced in Greater Huddersfield at the end of July 2020.

Regular COVID testing continues to be offered to Primary Care staff on a regular basis via Lateral Flow Tests (LFT) ordered through a central portal.

Currently patient testing is through the numerous community testing pathways currently available (drive through, mobile testing units, walk-ins, home test kit ordering online) rather than directly from GP practices.

COVID – Oximetry@Home

In December 2020, Kirklees GPs opted to commission one COVID Oximetry at Home (CO@H) service for the over 65 year old COVID positive population of Kirklees, which went live on 4 January 2021 (or younger people where clinically indicated). The service was commissioned from Local Care Direct with support from

Curo. In February 2021 PCN leads approved LCD access to NHS Digital daily data to allow early direct contact with eligible COVID positive individuals to offer the service. In March 2021, the referral age threshold was lowered to COVID positive individuals over the age of 50 years. As at March 2021, the CO@H service has received 218 referrals.

COVID Vaccinations

In December 2020, Primary Care Networks were asked to put forward proposals to mobilise PCN Local Vaccination Service (sites LVS) through an Enhanced Service to deliver COVID vaccinations at scale. The CCG was tasked with visiting, approving and ensuring the readiness and safety of the sites. Greater Huddersfield CCG has and continues to meet all National targets in relation to the COVID Vaccination Programme.

Staff at Cathedral House, Huddersfield celebrate achieving the Government target of inviting the top 4 priority categories for a vaccination (12 February 2021).

Three of the Greater Huddersfield Primary Care Networks (PCN) collaborated to vaccinate patients within their practices from Cathedral House. This site hosts Greenwood, Tolson and Viaduct PCNs, has the capacity to deliver 6,000 vaccines per week and was mobilised as part of wave one, on 15 December 2020. The Valleys PCN operates from Holme Valley Memorial Hospital, can administer up to

2,000 vaccines per week and was mobilised as part of wave three, on 22 December 2020. The Mast PCN operates from Kirkburton Health Centre, can deliver up to 1,000 vaccines per week and was mobilised as part of wave four, on 29 December 2020.

In Greater Huddersfield there are two Community Pharmacy sites: Boots, Huddersfield and Honley Pharmacy. These sites went live on 23 and 28 December respectively and can deliver up to 2,400 and 2,000 vaccines per week.

Greater Huddersfield also hosts the Kirklees Community Vaccination Centre, operating from the John Smith's Stadium in Huddersfield. This site went live as a staff vaccination site on 25 January 2021 and as a public facing site on 1 February 2021. The maximum weekly capacity is up to 15,120 vaccinations per week.

Calderdale and Huddersfield NHS Foundation Trust offered vaccinations, albeit, primarily to Health and Social Care Staff. Vaccinations were based in Acre Mills Outpatients. This site went live on 30 December 2020 and had a capacity of 2,100 vaccinations per week.

Greater Huddersfield vaccination sites continue to follow priorities set by The UK Government, as aligned to the National cohorts.

Practice Workload and COVID-19

In 2020-21, many of the requirements of practices and Primary Care Networks were stood down or reduced to free up capacity for the pandemic response. This took the form of income protection for many areas of contracts (e.g. Quality and Outcome Framework) and in the CCG agreed a number of local arrangements for local contracts and mechanisms to support practices such as obtaining PPE in the first few months of the pandemic or discretion to apply clinical prioritisation of services.

Medicines Management

The Medicines Management Team has supported the safe and effective rollout of the vaccination programme within Greater Huddersfield CCG by providing PCNs with:

- visits to potential vaccination sites to check their suitability as outlined by NHS England
- detailed clinical knowledge about vaccines, their storage conditions and legal aspects around administration
- regular assurance visits
- mutual aid when needed in form of trained vaccinators and admin staff

Additional to the vaccination programme, the Medicines Management team have engaged with:

- GP practices and care homes to support the setup of proxy ordering within care homes

- Kirklees Council to provide support to shielded patients with obtaining their medication
- GP practices and pharmacies to change repeat prescriptions to electronic Repeat Dispensing to reduce the burden on practices and ensure patient's access to regular medication
- Care homes and GP practices to provide information and support when needed as part of an Multidisciplinary team
- PCN clinical pharmacists to provide a forum for joint working to review and discuss existing priorities and prescribing, to provide guidance and advice to constituent organisations for them to consider and approve through their organisational approval processes as appropriate.

Access

It remains a key priority of the CCG and a key aim of the primary care strategy to provide easily accessible primary care services for all patients. During 2020-21, appointments in the evening and weekend were made available for all patients in Greater Huddersfield through an Extended Access service and through extended hours appointments delivered by Primary Care Networks. Along with GP practices, many of these appointments were delivered through video or telephone consultations with patients who needed to be seen face to face appointments being offered that option with appropriate safety measures in place.

The Extended Access Service in Greater Huddersfield works on a model of two central hubs (based at Huddersfield Royal Infirmary and the University Medical Practice) and a number of 'satellites' which are based in a number of individual GP practices who opt to provide Extended Access for their own patients. This suits some of the more rural areas in Greater Huddersfield. The service continued to offer a range of other services and clinicians such as phlebotomy, physiotherapy and cervical cytology and these were retained through the pandemic.

Primary Care Equitable Funding Review

At the September 2020 Governing Body Meeting, the CCGs approved a tiered service model as an approach to deliver Primary Care services consistently across Kirklees by GP member practices.

Participating GP practices moved to an equivalent of the core General Medical Services (GMS) contract payment rate to deliver Tier 1, core contractual services. In addition an extra circa £1 million investment was agreed into primary care across Kirklees to implement Tier 2, 'Kirklees Essentials' from the 1st October 2020. Greater Huddersfield and North Kirklees CCGs have now achieved the NHS England aspiration of equity of funding between contract types (GMS and PMS) by the 1st April 2021 by implementing Tiers 1 and 2. The programme of work is now moving on to review the CCG's local enhanced services and PMS premium schemes in Tiers 3 and 4 to achieve consistency for patients and practices.

Development of Primary Care Networks (PCNs)

Workforce

Each Primary Care Network has recruited their full complement of Clinical Pharmacists and Social Prescribing Link Workers that were introduced to PCNs in 2019-20. This ensured that patients from all practices have access to the skills that they bring and the support they can offer to the work of the PCN. The Clinical Pharmacist role has been very valuable in supporting practices with prescribing workload and in undertaking medication reviews. Social Prescribing Link Workers have played a really important role in 2020-21 in supporting patients during the pandemic, and in particular, patients who have been socially isolated due to shielding.

Every PCN has developed plans to recruit to the new additional roles that have become available. Using data and local knowledge about their populations' health needs, PCNs have identified the roles that they believe will bring most benefit to their patients and have started to recruit to the posts.

In 2020-21, the number of roles that PCNs could recruit to was significantly expanded and can be seen in the table below.

Role	Introduced
Clinical Pharmacists	2019/20
Social Prescribing Link Workers	2019/20
First Contact Physiotherapists	2020/21
Physician Associates	2020/21
Pharmacy Technicians	2020/21
Occupational therapist	2020/21
Dieticians	2020/21
Podiatrists	2020/21
Health and Wellbeing Coaches	2020/21
Care Co-ordinators	2020/21
Paramedics	2021/22
Mental Health Practitioners	2021/22
Nurse Associates	Oct 2020
Trainee Nursing Associates	Oct 2020

PCNs continued to have access to development funding and the time and budget allocated to the Clinical Director role was increased from 1 day per week to 5 days per week to account for the significant workload during the vaccination roll out.

Care Homes

Kirklees Care Home Programme builds on the key element and sub-elements of national PCN service specification for Enhanced Health in Care Homes (EHCH). The Framework lays out a clear vision for providing joined up primary, community and secondary, social care to residents of care and nursing homes via a range of in reach services.

The EHCH model has three principal aims:

- delivering high-quality personalised care within care homes;
- providing, wherever possible, for individuals who (temporarily or permanently), live in a care home access to the right care and the right health services in the place of their choosing; and
- enabling effective use of resources by reducing unnecessary conveyances to hospitals, hospital admissions, and bed days whilst ensuring the best care for people living in care homes

In the EHCH model, care providers work in partnership with local GPs, community healthcare providers, hospitals, social care, individuals and their families, and wider public services to deliver care in people's homes as well as in care homes. Services are 'wrapped around' the individual and their family, who are connected to and supported by their local community. Proactive, personalised care and support becomes the norm.

To complement the EHCH framework a number of requirements to support care homes were developed in 2020-21 as part of the COVID response, including:

- Identifying a clinical lead for each care home
- Providing a weekly check-in for each care home.

In order to achieve this and meet the requirements of the EHCH Enhanced Service, practices across Kirklees have aligned one practice to one care home. Each practice has an identified clinical lead that participates in the weekly home round / check in. Practices have worked closely with care home colleagues to provide virtual consultations using AccuRX.

Practices are also supporting care home colleagues during the COVID outbreak and are assisting to embed the SBAR (Situation, Background, Assessment, Recommendation) tool which is used to facilitate prompt and appropriate communication where the care home is concerned about a resident.

Practices are currently working with their aligned care home to ensure robust processes are in place to support their weekly home round and MDT meetings. Practices are working collaboratively with our community provider to ensure appropriate residents have advanced care plans incorporating treatment and escalation plans in place. Other work has begun to test digital solutions in care homes.

All the above initiatives have supported the development of improved communication and closer working relationships between practices and care homes resulting in better outcomes for residents

Digital

GP online Consultation and video consultation

Patients registered at all 37 Greater Huddersfield practices have been able to access their GP practice via the utilisation of the GP online E-Consult System. Through this system patients are able to communicate securely and safely online with their practice about non-emergency medical conditions or ask administration questions. The system also offers 24/7 access to symptom-specific self-help information and easy access to other local NHS and self-care services.

Since April 2020 and throughout the COVID19 pandemic, all GP practices have had access to utilising AccuRx, providing a way for video consultations to take place between practice staff and patients in a secure and accessible format.

GP online consultations, IT and digital first

From June 2020, all practices were offering both online and video consultations to patients. This enables practices to triage patients safely and remotely to support the Covid-19 response. The CCG reviews reports of utilisation and patient feedback for online consultation every month.

Engagement with membership and practice visits

As a membership organisation, the CCG supports the provision of education and training opportunities that cultivate professional excellence and high motivation. Where possible, this is done at scale in collaboration with partners and the GP Federation.

Regular ‘Practice Protected Time’ events took place in 2020-21 delivered with the support of My Health Huddersfield GP Federation and the adoption of technologies enabled events to continue remotely. Events are also arranged which focus on the learning and development needs of nursing and practice management colleagues.

My Health Huddersfield have worked closely with Practice Managers and wider teams to deliver the THRIVE programme of structured Quality Improvement techniques for general practice. Particular highlights have been the training of practice staff as Mental Health First Aiders – this is now available in every practice, and of a project to increase the uptake of physical health reviews for people with severe mental illness.

In 2020-21, the CCG continued a programme of Membership Engagement Events, moving these to online and supportive practice visits. These worked alongside a

programme of Quality Assurance Visits and the regular review of a comprehensive quality and contracting dashboard.

Financial Performance

Due to the impact of the pandemic the CCG has seen some its usual financial targets suspended for the year, except for achieving a breakeven position and our key financial duties that are shown below. For 2020-21 the CCG has successfully achieved a surplus position for the year of £0.751m, against its breakeven target.

During the year the CCG has continued to utilise the resources it has received by targeting areas of greatest need. The CCG has invested significantly in areas such as Primary Care, to support the pressures experienced in this area. It has also developed several services in primary care, the care sector and within the community to support the ongoing response against Covid-19.

Due to the challenges this year has brought, the CCG has still looked to deliver new services that will be even more important as we move forward. The CCG has continued to make investments that include –

- Investment in primary care where the CCG has tackled the inequities in contract values.
- Continued to make investment and development in mental health services
- Development in Care Homes Services
- Development of community services.

The CCG has also continued to support West Yorkshire programmes of care as part of its wider system work within the Integrated Care System.

Financial Duties

The CCG has several statutory financial duties and targets against which its performance is monitored. Although the CCG has had a number of its financial targets suspended, we are pleased to report that we were able to achieve our financial plan and 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 all 4 of the indicators relating to payments made within 30 days.

The table below shows a summary of the CCG's performance against the statutory financial duties in 2020-21:

Financial Duty	Achieved/Not Achieved	Performance in 2020-21
Achieve operational financial balance	**Achieved**	Delivered in-year surplus of £0.751m, cumulative surplus £5.192m
Maintain capital expenditure within Capital Resources	**Achieved**	£0k of capital resource utilised against a limit of £0k
Manage cash within the CCG's Cash Limit	**Achieved**	Cash balance of £0.165k

Non-financial Matters

Throughout the Annual Report, details are shared of the CCG's focus on social matters (for example, the KJSA), our respect for human rights (for example, our compliance with statutory duties), and our commitment to anti-corruption and anti-bribery (for example, the Governance Statement details our management of risk).

Sustainability Report

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

National Ambition

NHS Vision:
To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.

The NHS was founded to provide high-quality care for all, now, and for future generations. Understanding that climate change and human health are inextricably linked, in October 2020, it became the first in the world to commit to delivering a net zero national health system. This means improving healthcare while reducing harmful carbon emissions, and investing in efforts that remove greenhouse gases from the atmosphere.

With around 4% of the country's carbon emissions, and over 7% of the economy, the NHS has an essential role to play in meeting the net zero targets set under the Climate Change Act (Delivering a 'Net Zero' National Health Service).

Two clear and feasible targets are outlined in the Delivering a 'Net Zero' National Health Service report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

In Kirklees

In March 2020, the West Yorkshire and Harrogate Health and Care Partnership published its response to the NHS Long Term Plan. In this, the CCG in partnership with other West Yorkshire CCGs, NHS providers and local authority partners identified climate change as one of the key priorities requiring action over the next five years.

In support of this, the CCG has commenced work on a Green Plan (jointly with North Kirklees CCG), to replace the former Sustainable Development Management Plan; however work has been delayed by the CCG's response to the coronavirus pandemic during 2020-21.

A Green Plan is a mechanism for organisations to take a coordinated, strategic and action-orientated approach to sustainability. Developing a Green Plan will help the CCG to:

1. Deliver on the Long-Term plan
2. Improve the health of the local community
3. Achieve its financial goals
4. Meet its legislative requirements

Summary of Performance

The CCG moved into new premises part way through 2019-20, and therefore were unable to determine baseline performance for carbon emissions last year. 2020-21 will provide a baseline year for performance, however it should be noted that it has not been a typical year due to the coronavirus pandemic, when the majority of CCG staff have been working from home since March 2020.

Resource	Unit	Consumption 2020-21	Carbon Emissions 2020-21 (tonnes CO_2e)
Electricity	kWh	15,202*	10.8
Gas	kWh	The CCG does not have a gas supply at its headquarters.	
Water	m^3	The CCG is a tenant in a multi-occupier building and makes a contribution towards water as part of its service charge. It is not possible to identify the consumption attributable to the CCG, or the carbon emissions connected with this.	

* The CCG is a tenant in a multi-occupier building and is charged a percentage of usage from a number of meters covering the building. The usage is further split 50:50 with North Kirklees CCG due to staff being shared and using communal space.

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:

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.

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:

- Kirklees Joint Strategic Assessment (KJSA) Overview 2020-21 and Director of Public Health Annual Report 2020-21
- Kirklees Inclusion Commission and Development of Kirklees Joint Health and Wellbeing Strategy
- Kirklees Children and Young People Plan
- Kirklees Health and Wellbeing Plan
- Kirklees wide approach to Health Inequalities
- Establishment of Kirklees Integrated Health and Care Leadership Board
- Pharmaceutical Needs Assessment

The Board has focussed extensively on COVID-19 during the past 12 months, and areas of focus have included:

- Community Engagement during COVID-19
- Implication of COVID-19 for Kirklees

- Stabilisation and Reset across Kirklees Health and Social Care System
- Kirklees Outbreak Control Plan

Ensuring the continuous improvement in quality

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

Improving quality of health care and ensuring patient safety is a key role of the CCG. During this challenging year we have adapted our quality work by offering expert clinical and quality support to our provider colleagues, and we have adapted a proportionate, pragmatic approach to quality assurance.

In addition, in response to the Chief Nursing Officer asking CCGs to lead an Infection Prevention and Control and Personal Protective Equipment training package to 100% of all care home providers, including Learning Disability homes the CCG Quality team co-ordinated and delivered this phased programme on May 1st with completion of the final phase required on 29th May. The programme was required to ensure understanding and compliance with guidance and safe practices and involved identification and training of an identified number of Supertrainers who educated and assessed trainers as competent to deliver training with a required ratio of trainers depending on the number of homes.

100% offer was achieved within the required timescale, with training sessions delivered to 88 out of 127 open homes in Kirklees. Homes who declined the offer had often already done alternative training, and some were unable to accommodate this within the timescale and by September 29th 100 of 127 open homes had received training. Supplementary training sessions were offered to deliver the training to more care home staff and embed good practices.

We have ensured that we have fulfilled the requirement to assure ourselves on the quality and safety of service provision. We have done this by:

- Further developing the strong working relationships with our providers through CCG quality attendance at all provider Quality committees . Maintaining robust insight on quality performance through the scrutiny of the quality and safety dashboards.
- Adaptation of the Quality Impact Assessment process to support colleagues within the organisation respond to rapid service change required by the pandemic.
- Delivery of a national training programme on Infection Prevention and Control plus Personal Protective Equipment to all care home providers, including Learning Disability homes to ensure understanding and adherence to recommended guidance.
- Provision of an offer of ‘Soft Signs-Recognition of deterioration’ to all care home providers including Learning Disability homes to assist staff in

understanding how subtle, non-specific changes in residents can be important and what to do to obtain appropriate timely help.

- Participate in outbreak management processes and support any identified required quality improvements.
- Confirmation of organisational compliance from providers against the national Infection prevention and control Board Assurance Framework internal assurance as well as ongoing updates against the Trusts Infection and Control action plan.
- Supporting Primary Care Networks to plan safe Covid vaccination delivery which provide a positive patient experience.
- Provision of an offer of 'Fresh Eyes' Infection Prevention and Control support visits to primary care settings both proactively and in response to staff outbreaks.
- Continue to progress both the Quality for Health assurance system developed by the CCG and VAC for the voluntary sector plus request scoping into provision and resilience of the local Third Sector to identify gaps in areas of CCG priority.
- Sharing patient stories at every Governing Body meeting in order to learn about experience of accessing health services including experience of Covid vaccination.

Safeguarding Adults and Children

The CCG has a legal responsibility to ensure that the principles and duties of safeguarding children and adults at risk remain a priority for both the CCG and the providers from which it commissions services. Whilst some statutory duties under the Care Act 2015 were eased during the past year due to the Covid Pandemic, the duties relating to safeguarding remained.

The safeguarding functions continued, albeit some delivered in different ways:

- **Supportive safeguarding advice**: The CCG Safeguarding team offered advice to support professionals in the CCG or Primary Care and extended the offer to include staff in commissioned health providers
- **Responding to urgent statutory safeguarding cases**: Significant statutory safeguarding cases require responsive actions to ensure that any learning is shared quickly to protect children or adults who may be at risk. The CCG Safeguarding Team continued to support the work on these cases throughout the year.
- **Work to support the Kirklees Safeguarding Boards/Partnerships:** The Safeguarding Board/Partnership Executive meetings continued and the CCG as a statutory member continued to attend and play a full role. Initially subgroups and work-streams of the Board/Partnerships were suspended, but these were re-commenced via virtual processes and the CCG are in full attendance

- **Supporting Primary Care and other partners with pertinent safeguarding information:** Supportive guidance for both safeguarding and adherence to the mental capacity act during the pandemic have been produced by the Team and distributed to Primary Care colleagues.

Seeking assurance that commissioned providers continue to prioritise and deliver safe and effective systems for safeguarding children and adults, including provision for Children in Care and a Child Death Overview Panel, remains a key part of the CCG Safeguarding team role.

The Learning Disabilities and Mortality Review Programme (LeDeR) update

The LeDeR programme was established in 2017. Locally the CCG leads the programme of retrospective reviews the deaths of people with Learning Disabilities (LD) aged 4 to 74 across England. The key aim being: to identify learning and best practice so that any recommendations for improvement can be taken forward.

NHSE requirements are that a trained LeDeR Reviewer must be allocated within 3 months and the review completed within 6 months. The most significant challenge for the CCG has been has been limited funding to support the delivery of reviews and the majority of Reviewers continue to complete these in addition to their substantive posts.

With the support of local Health Providers and Local Authority partners a shared approach across Calderdale and Kirklees to complete the reviews was undertaken with success, as all backlog cases for the two areas were completed by December 2020

In November 2020 NHSE published a report analysing the LeDeR Reviews that had been undertaken of the deaths of 206 people with LD at the start of the pandemic. The report highlighted some good practice in the care of people with LD, but it also highlighted concerns in 4 key areas:-

- Issue 1: Identifying deterioration in health.
- Issue 2: Do not attempt cardiopulmonary resuscitation (DNACPR) and learning disability as a cause of death
- Issue 3: Diagnostic overshadowing
- Issue 4: Reasonable adjustments

The learning from the report in November 2020 has been taken forward by local commissioners of service for people LD, this remain as a key priority to addressing inequalities for people with LD.

Public Involvement and Consultation

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

We have a strong commitment to involving the public and patients. Our communications and engagement strategy sets out how we involve our main stakeholders and fulfil the duties identified in Section 14Z2 of the NHS Act 2006.

Below is a summary of the mechanisms we use to seek views from and share information with patients, carers, community and voluntary sector, and general public. You'll find more details on our website and in our annual statement of involvement.

The Patient and Community Engagement Indicator evidences compliance with statutory guidance as part of the NHS Oversight Framework. This year, we achieved an outstanding rating [Green Star] with a score of 15 out of a possible 15. More details are available on the NHS England website here: https://www.england.nhs.uk/participation/involvementguidance/ccg-iaf/

Your health, your say network

We maintain a database of local people who want to get involved in the development of new and existing services and share their experiences of local healthcare.

GP practice patient reference groups

Patient reference groups are designed to give people the opportunity to contribute to the continuing improvement of their GP practice.

Patient reference group network

This network has been set up by the CCG. It brings together representatives from GP practice patient reference groups to learn more about our commissioning plans consider and discuss proposals and engage with us on decision making. The group met 4 times this year and discussed the national GP survey results; GP online consultations; flu vaccination programme; primary care Networks; creating a single clinical commissioning group for Kirklees. It also received regular updates on how the CCG was dealing with the pandemic.

Patient engagement and assurance group

This group provides assurance that the CCG involves patients, carers and members of the public when it plans, develops and purchases, or in some cases discontinues, health services. There were 4 meetings of the group in 2020-21 and discussions included the engagement plan for Broughton House surgery and future configuration of the CCGs. It also reviewed the CCG Communications and Engagement Strategy and received updates on personalised care; primary care networks; equality objectives; and integration.

Quarterly public events

Our events are open to members of the public and representatives of voluntary and community sector organisations. We've been running public events jointly with NHS Greater Huddersfield CCG/NHS North Kirklees CCG since July 2019. Due to the COVID-19 pandemic, a meeting scheduled for April 2020 was cancelled. We were able to resume events in June using online meeting technology and therefore held three of the four planned sessions during the year. Topics discussed included regular updates on how the CCGs were dealing with the pandemic; North Kirklees CCG recovery plan; flu vaccination programme; hospital service reconfiguration in Halifax and Huddersfield; and the merger of the two Kirklees CCGs.

Engagement and consultation

In line with our statutory duties, we seek the views of local people to learn more about their experiences and expectations of health services and inform commissioning decisions. During the year we engaged about creating a single clinical commissioning group for Kirklees; using maternity services during COVID-19; and sought views from patients at Broughton House Surgery.

Community and voluntary sector

We very much value the support and challenge provided by community and voluntary sector organisations in Kirklees. We work with community organisations on specific engagement projects, encourage them to help us share important public health messages, and meet with them regularly through our public engagement events. We also work with Greater Huddersfield CCG/North Kirklees CCG to recruit and train Community Voices - individuals who engage with the local population on our behalf.

Communication campaigns

The start of the COVID-19 pandemic saw the CCG re-prioritise its communications effort and focus on sharing national NHS information about the virus, supporting public health messaging, and providing information about how local health services were working – particularly GP services.

The CCG also supported colleagues across West Yorkshire to promote uptake of the COVID-19 vaccine; shared information and guidance about the local vaccination programme; and developed positive stories, such as the first jabs being given in Kirklees and the opening of the John Smith's Stadium vaccination centre.

As part of our pandemic response, we also worked with neighbouring CCGs, GPs, healthcare professionals, and Kirklees Council to develop a range of locally-focused material including press releases, short films and social media posts.

Alongside the COVID-19 response, we promoted the NHS 'Help us, help you' campaign, which was designed to encourage people back into NHS services; used self-care week in November to focus on a range of conditions such as diabetes and mental health; promoted the NHS flu vaccination campaign; and joined-up with colleagues across West Yorkshire and Harrogate to support the latest phase of the 'Looking out for our neighbours' campaign.

As part of our 'winter messages' promotion, we worked with VAC to undertake a range of community-based activities to highlight appropriate use of NHS services.

In February we launched the *Check-In* campaign, which aims to prevent staff suicide and promote a wellbeing culture by normalising the conversation around suicide and mental health as well as providing training, resources and signposting for support.

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**

Carol McKenna

Chief Officer

11 June 2021

Corporate Governance Report

Members Report

Member practices

NHS Greater Huddersfield CCG is a membership organisation that consists of 37 GP practices as at 31 March 2021:

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
Rose Medical Practice	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

Our Clinical Chair is Dr Steve Ollerton.

Our Accountable Officer is Carol McKenna.

Our Governing Body

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

Required Composition	Individuals in Post
8 representatives of member practices, one of whom shall be appointed as chair	Dr Steve Ollerton (Chair) Dr Razwan Ali Jenny Cullearn Alix Ewen (until 12 June 2020) Dr James Morton (until 23 September 2020) Dr Amjid Rehman (from 14 July 2020) Vacancies
3 lay members, one of whom will act as deputy chair: • Patient and Public Involvement • Audit, Governance & Conflicts of Interest • Finance & Remuneration	 Beth Hewitt Martin Wright Hilary Thompson
1 registered nurse advisor	Vacancy
1 secondary care advisor	Dr Chunda Sri-Chandana (until 31 October 2020) Vacancy (from 1 November 2020)
3 executives: (i) Chief Officer (ii) Chief Finance Officer (iii) Chief Quality & Nursing Officer	 Carol McKenna Ian Currell Penny Woodhead

The Governing Body is supported in its work by two advisors from the Local Authority – the Strategic Director for Adults and Health and Director of Public Health.

Our Committees

Our Governing Body has appointed a number of committees:

- Audit Committee
- Finance, Performance & Contracting Committee

- Primary Care Commissioning Committee
- Quality Committee
- Remuneration Committee

The CCG is also a member of the West Yorkshire & Harrogate Joint Committee of CCGs.

For further information on all our Committees, including their terms of reference and membership please see the Governance Statement (page 61).

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: https://nkgh-ccg.co.uk/lists-and-registers/ A copy of the CCG's Register of Procurement Decisions can also be viewed on the CCG's website.

Personal Data Related Incidents

The CCG has had no serious personal data related incidents which have required reporting to the Information Commissioner.

Statement of Disclosure to Auditors

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

- So far as the member is aware, that there is no relevant audit information of which the CCG's 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.

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 a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the 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 NHS Greater Huddersfield CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

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.

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 CCG'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 2020, the CCG 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 CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out 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 CCG 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 CCG 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.

CCGs – Journey to Merger

Greater Huddersfield and North Kirklees CCGs have a long history of working together to commission health services and this collaborative approach has continued to strengthen over recent years. For the last 3 years, the CCGs' Governing Bodies have been meeting in parallel with each other, which means that the meetings happen at the same time in the same place, with the Governing Bodies of both CCGs sat around the table. Each Governing Body has been separately chaired, and each Governing Body has managed its own quoracy, conflicts of interest, and made its own independent decisions. This same approach has also been used for Audit Committees; Finance, Performance & Contracting Committees; Quality Committees; and Remuneration Committees. Each CCG has had its own Primary Care Commissioning Committee, meeting separately, with a focus on local primary care issues.

Much has been achieved through joint working over the last few years; we have been able to:

- Strengthen the breadth and depth of leadership and management support.
- Play a full role, building our influence, within the ICS.
- Streamline CCG functions & teams.

- Appoint external governance roles in common across the two CCGs.
- Move to a single shared headquarters.
- Reduce running costs without impacting adversely on patients or member practices.
- Improve job satisfaction and support for our staff.
- Share best practice between the CCGs to the benefit of patient care.

The NHS Long Term Plan sets out the strategic direction for commissioning as a framework of strong primary care networks, greater integration with local authorities at place level and increased collaboration between leaner, more strategic Clinical Commissioning Groups across Integrated Care Systems. In that context, and as required by NHS England, it was right to consider whether the continuation of Greater Huddersfield CCG and North Kirklees CCG as two separate statutory organisations was the best way to support the needs of the Kirklees population into the future. Both CCGs therefore undertook an extensive piece of work to consider the future, with the decision about the future structure of each CCG resting with the membership of that CCG. This first started in early 2019 and in last year's annual report, it was explained that in March 2020 the member practices of each CCG had voted on whether they supported the creation of a single CCG for Kirklees. A majority of Greater Huddersfield member practices voted in support of this proposal. A majority of North Kirklees member practices voted against it. As the creation of a single Kirklees CCG required the support of both sets of member practices, we moved forward into 2020-21 as two separate organisations, exploring the detailed implications for each organisation of the decision not to merge and continuing to work in close partnership.

In the days following the membership vote in March 2020, the world significantly changed. Relationships between practices, Primary Care Networks, GP Federations, Local Medical Committees, Kirklees Council, the CCGs and providers transformed as the NHS collectively responded to COVID-19.

In November 2020 North Kirklees clinical leaders felt that given this new set of circumstances they should ask member practices to revisit their previous decision and a majority of North Kirklees member practices confirmed that they were now supportive of creating a single Kirklees CCG. Greater Huddersfield member practices confirmed that they remained supportive. Following confirmation of this membership support, both Governing Bodies on 25 November 2020 agreed to support an application to NHS England to dissolve the two existing CCGs and to establish a single Kirklees CCG from 1 April 2021. Following an assessment process, NHS England & Improvement agreed in principle to the proposed merger and establishment of NHS Kirklees CCG, and subsequently authorised this ahead of 1 April 2021.

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.

As at 31 March 2021, the membership comprised of four practice representatives (including the chair) as endorsed by the membership (with four vacancies); three lay members (one of whom is the deputy chair and leads on finance and remuneration matters, one who leads on audit, governance and conflict of interest matters, and one who leads on public and patient involvement) one registered nurse (vacant); one secondary care specialist (vacant); the Chief Officer (as Accountable Officer), the Chief Finance Officer and the Chief Quality & Nursing Officer.

The Director of Public Health and the Strategic Director for Adults and Health 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 held a number of vacancies as they arose during 2020-21 as the CCG worked towards merger with North Kirklees CCG. Recruitment to the new CCG commenced in January 2020.

Committees of the Governing Body

In 2020-21, the Governing Body had five committees to support its work. The full terms of reference of these committees are available at https://nkgh-ccg.co.uk/

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, the Risk Management Framework, and Emergency Planning.

The Committee reflected that it had met its terms of reference, providing assurance to the Governing Body that the CCG has effective controls and processes in place to manage the significant risks to achieving its strategic objectives. The Committee also played an important role in reviewing the CCG's amended financial, quality and corporate governance arrangements during the COVID-19 pandemic.

Finance, Performance & Contracting 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 its work during 2020-21:

- The Committee has continued to hold part of its meeting jointly with the Quality Committee, which has enabled members to learn from each other's expertise and enabled more robust challenge and scrutiny.
- The Committee discussed the learning it would like to share with the new Kirklees CCG's Finance, Performance and Contracting Committee.

Primary Care Commissioning Committee

The role of the committee is to commission primary medical services for the people of the Greater Huddersfield area, under full delegation from NHS England. The committee carries out functions relating to the commissioning of primary medical services under Section 83 of the NHS Act. The Committee has identified the following highlights from its work during 2020-21:

- Utilisation of new technology to hold virtual meetings, and the development of new skills.
- Decisions made swiftly and flexibly using urgent decision-making processes.
- Maintaining oversight through regular Covid-19 updates.
- Healthwatch report on patient experiences during Covid-19

Quality 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 the 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 its work during 2020-21:

- The Committee has continued to hold part of its meeting jointly with the Finance, Performance and Contracting Committee, which has enabled members to learn from each other's expertise and enabled more robust challenge and scrutiny.
- Significant focus on assurance around commissioned services and managing to retain robustness despite moving at pace during the response to the

pandemic. The Committee are keen to ensure that learning from the adapted governance is captured, and where it has worked well, taken forward.

Remuneration Committee

The role of the committee is to make decisions, under delegated responsibility from 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. During 2020-21, the Committee reflected that it had fulfilled its terms of reference, offering an independent and unbiased decisions and recommendations. The Committee had welcomed the opportunity to develop a deeper understanding of remuneration and HR contracts.

West Yorkshire & Harrogate Joint Committee of CCGs

The Joint Committee is part of the West Yorkshire & Harrogate (WY&H) Health & Care Partnership (HCP), and enables the WY&H CCGs to work together effectively – making sure that when it makes sense, work is done once and is then shared across WY&H. It was established in May 2017 and has delegated authority from the CCGs to take collective decisions on agreed priorities. As well as taking formal decisions, the Committee also makes recommendations to the CCGs when a joint approach will help to achieve better outcomes.

The members of each CCG have agreed the Committee's terms of reference and its work plan, which sets out the decisions for which it is responsible. The Committee is made up of 2 representatives from each of the WY&H CCGs – Carol McKenna, Chief Officer, and Dr Steve Ollerton, Clinical Chair represent Greater Huddersfield CCG. To ensure that decision making is open and transparent, the Committee has an independent lay chair and two lay members drawn from the CCGs. Representatives from the Partnership Team and NHS England also attend.

Reports to the Committee identify the patient and public involvement that has already taken place or is planned to inform any commissioning proposals. In this way, the Committee ensures that the voice of patients is at the centre of its decisions. To support this process, the Committee has established a PPI Assurance Group. Committee meetings are held in public and are also streamed 'live' on the internet.

The text below is a summary of the full annual report of the Committee, which is available to view on the HCP website at: https://www.wyhpartnership.co.uk/application/files/3716/2124/5735/WYaH_Joint_Committee_of_CCGs_Annual_Report_2021.pdf

The role of the Joint Committee

The Committee has delegated authority from the WY CCGs to take joint decisions on agreed priorities. The Committee also makes recommendations when a collaborative approach across WY&H will help to achieve better outcomes. The Committee has an independent lay chair, three CCG lay members and two representatives from each WY CCG. North Yorkshire CCG is an associate member. As a result of COVID-19, all meetings were held virtually in 2020/21 and were live streamed. The attendance record is at page 90.

The Committee has a Public and Patient Involvement Assurance Group made up of lay members from each CCG. The Group provides assurance that public and patient voice informs the Committee's decisions.

1. Improving outcomes

Responding to COVID-19

The Committee considered how WY&H health and care programmes had refocused to support the response to COVID-19. The Committee agreed that its work during the year would need to evolve to reflect the new priorities arising from COVID-19.

West Yorkshire and Harrogate Healthy Hearts

In 2018, the Joint Committee recommended the CCGs to adopt the Healthy Hearts improvement project, building on successful work in Bradford. The project aims to identify more people with high blood pressure, help them to control it better and reduce the risk of heart attacks and strokes. As a result, 22,000 more people have had their blood pressure controlled to target numbers. WY&H Healthy Hearts won the Health Service Journal Cardiovascular Initiative of the Year award in 2020.

Assessment and Treatment Units (ATUs) for people with complex learning disabilities

The Committee supported a proposal to commission a new care model for people with a learning disability. This involved collaborative commissioning between commissioners and providers across the whole pathway for people with learning disabilities. The aim is to develop a single system and centre of excellence. The Committee noted plans for engaging with people who had accessed care in ATUs, their carers and staff. Formal approval for the proposals was sought at a meeting in 2021/22, following further engagement.

Urgent and emergency care

The Committee supported a national programme which built on learning from COVID-19. It encouraged people to phone 111 as an alternative to 'walking' unheralded into Emergency Departments (EDs). The integrated offer included alternative pathways, for example GPs, pharmacists and mental health advice. Patients are remotely triaged to determine if there is a clinical need to be seen face to face.

The Committee considered a report on primary medical care services in West Yorkshire, which were provided by Local Care Direct (LCD). The response to COVID-19, changes in national policy and potential changes to the commissioner landscape meant that there was uncertainty about what should be commissioned for the future. The Committee felt that in the current circumstances a pragmatic approach should be taken and agreed to extend the service from LCD for three years.

Improving planned care

The Committee supported changes to the Improving Planned Care programme, which focused on restarting planned care following the first wave of COVID-19. This included improving access to diagnostic testing services and more shared decision making between primary and secondary care.

The Committee approved an amendment to a WY&H policy for flash glucose monitors - small sensors worn on the skin for monitoring the glucose levels of people with diabetes. The amendment covered type 2 diabetes patients with learning disabilities who need to use insulin. Self-management of diabetes by patients with learning disabilities would promote independence and reduce health inequalities.

The Joint Committee had previously agreed a number of clinical threshold policies, which had improved equality of access across WY&H and reduced levels of surgery where non-surgical interventions could be more effective.

Stroke

In 2018, the Joint Committee agreed a common approach for commissioning hyper acute stroke services and all stages from prevention to recovery. The specialist hyper-acute stroke pathways are now well established, with 4 units providing hyper-acute care during the first 72 hours following stroke across WY&H. A sustainable stroke clinical network has been established, working to provide the best stroke services possible and further improve quality and stroke outcomes in each of our six places. Priorities include preventing strokes, delivering effective care when people have a stroke and ensuring that there is good support and rehabilitation for people after a stroke.

2. Working better together

The Committee led new approaches to collaborative working between commissioners and providers. The Commissioning Futures programme was developed in collaboration with partners across the health and care system, based on our successful model of place-based working. Work is only carried out at WY&H level if it adds value to our places

The Committee supported collaboration between commissioners and providers through the Cancer Alliance, Improving Planned Care programme, Local Maternity System and Mental Health, Learning Disability and Autism Alliance. The Committee also supported the Yorkshire and Humber framework for integrated commissioning of Integrated Urgent and Emergency Care Services provided by Yorkshire Ambulance Service.

3. Governance

In 2020, the WY CCGs agreed a revised Memorandum of Understanding for Collaborative Commissioning, which included a new work plan and the delegation of new commissioning decisions to the Joint Committee.

The Committee maintains a register of members' interests and declarations of interest are a standing item on all agendas. At each meeting, the Committee reviews the significant risks to the delivery of its work programme and assesses how these risks are being mitigated.

Membership and Attendance Records

Details of the membership of the Governing Body and Committees (including the Joint Committee) are set out on page 88 – this includes each member's attendance record over the past year.

Governing Body – Assessment of Performance and Effectiveness

The Governing Body regularly spend time in development mode, alongside North Kirklees CCG's Governing Body, reflecting on their performance and effectiveness and during 2020-21 this has focused on two key elements – COVID-19; and working towards merger of the two CCGs. Work to develop an Organisational Development Plan has focused on getting ready for the new merged CCG.

In March 2021, the Governing Body met in development mode with North Kirklees CCG's Governing Body to create a virtual 'time capsule' celebrating the work of the CCGs since April 2013, and looking ahead to the new Kirklees CCG from 1 April 2021. Members of the Governing Body reflected on the successes of the CCG,

identified learning to the be taken forward into the new organisation, and helped to shape the induction plan for new Governing Body members.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, the CCG believes it to be good practice to demonstrate its compliance with relevant principles of the Code in a way that is commensurate with the size, status and legal framework of the organisation. We have therefore 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:

- **Board Leadership and Company Purpose**
  - Details of the Governing Body within the Corporate Governance Report
  - Details of the CCG's strategic objectives and performance within the Performance Report
  - Details of engagement work within the Performance Report
- **Division of Responsibilities**
  - Details of the Governing Body and its review of its own performance and effectiveness within the Corporate Governance Report
- **Composition, Succession and Evaluation**
  - Details of the Governing Body, its committees, and their effectiveness within the Corporate Governance Report
- **Audit, Risk and Internal Control**
  - Details of the Audit Committee within the Corporate Governance Report
  - Details of the Risk Management Framework within the Corporate Governance Report
- **Remuneration**
  - Remuneration and Staff Report, within the Annual Report

The CCG's Audit Committee undertakes monitoring of the CCG's compliance with the provisions of the Code, identifying where action is needed.

Discharge of Statutory Functions

In light of recommendations of the 2013 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 from 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 who has 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:

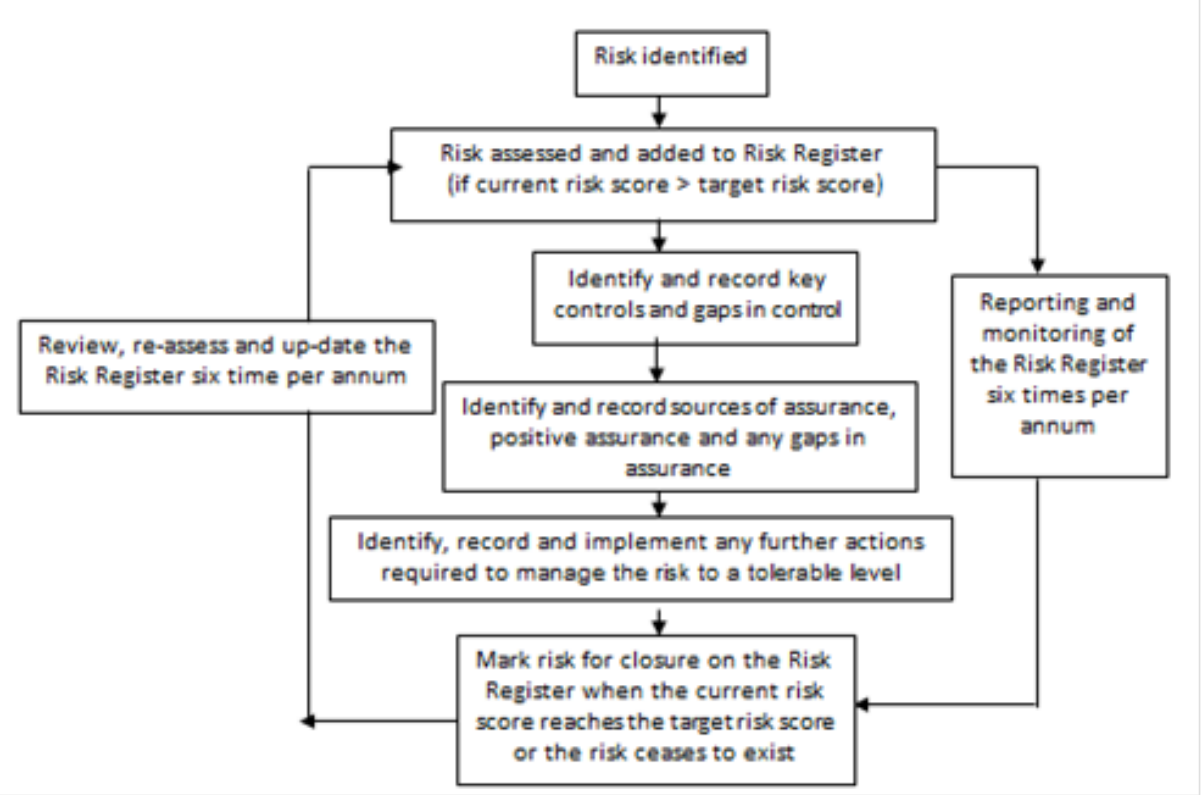
1. Identify, Report and Manage Risk and Embed within the Commissioning Process

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 Committee, Finance, Performance & Contracting 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:

- Identify a risk
  - Under potential impact
  - Examine control measures and their effectiveness
  - Decide if further actions necessary
  - Score risk and categorise potential of any outstanding risk

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

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 Governing Body Assurance Framework is reviewed regularly 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.

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 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 which have their own programme level risk registers and which are captured on the CCG's main risk register. In April 2020, the CCG introduced a dedicated risk register for the management of COVID-

19, and this ran until September 2020 when the remaining risks were either closed or moved onto the corporate risk register.

The CCG's key control mechanisms of the Risk Register and Governing Body 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. We have identified below those risks to governance, risk management and internal control deemed to be major (ie scoring 15 or above) up to 31 March 2021:

Risk	How CCG has acted to manage the risk	How outcomes will be assessed
That the CCGs will fail to achieve both local and the national performance standards (set out in the NHS constitution), due to the impact of the national covid-19 pandemic & the NHS E directive to stop all non-essential services & elective procedures, resulting in a negative provider performance, patient experience & outcomes.	• Acute based planned care & urgent care groups, to discuss performance & impact monthly • Routine operational & tactical discussion on a Daily & weekly basis between senior SMT managers & Clinicians • Updates provided to SMT Gold	• Monthly reports to committees and GB • Covid-19 risk register • Commissioner / provider task & Finish groups • Regional NHS E/I world café session to plan & review • Stabilisation & reset
That the CCG is unable to deliver on its part of the national expectations to deliver the Covid 19 vaccine due to; the lack of workforce, vaccine supply, vaccine instability, or the appetite of our population, resulting in our population not being protected from the virus, higher morbidity and mortality, continued high demand for health and care services and in inability to restart the local economy.	• WY ICS SRO Programme established at WY (meetings twice weekly) • Kirklees Programme developed • Kirklees Health Protection Advisory Group receiving updates for assurance	• Monitoring of vaccine uptake
Not being able to effectively plan and sufficiently resource the Data Security	• Work Plan focusing on DSPT related work packages	• Mandated Internal Audit of the DSPT 20/21 for assurance, prior to

Risk	How CCG has acted to manage the risk	How outcomes will be assessed
and Protection Toolkit (DSPT) work programme activities for 2020/21, due to a. significant delay in the DSPT online tool being made available; b. significant number of the evidence lines (including new) having a dependency on actions of a third party; c. enhanced and prescriptive internal audit scope; d. earlier submission deadline for merging CCGs; leading to an increased risk of non-compliance against mandatory sub-assertions and a standards not met toolkit submission for 2020/21.	• Monthly IG Leads Meeting • SLA in place with The Health Informatics Service in relation to provision of IT and cyber security services. • Additional resource realigned to the IG team. • Confirmed reduction in published mandatory evidence requirements specifically relating to the IT evidence lines.	submission of the CCG's self-assessment. • Submission by 31 March 2021 of 'Standards Met' Toolkit

The CCG's **Governing Body Assurance Framework** describes the principal risks to compliance with our licence and being able to fulfil our strategic objectives. Each strategic objective and the principal risks to achieving these are set out in detail at page 13, together with risks identified as underlying risks across all strategic objectives.

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 Governing Body 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:

  - Risk register is updated.
  - Risk register is reviewed by Senior Management Team.
  - Risk registers are submitted to Finance, Performance & Contracting Committee and Quality Committee. Audit Committee review the High Level Risk Log.
  - Governing Body receive the High Level Risk Log and minutes of meetings from Committees.

- *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 & Contracting Committee and Quality Committee.
  - Discussions taking place at Finance, Performance & Contracting Committee and Quality Committee on the Risk Register and the Governing Body Assurance Framework, complemented by assurance discussions at the Audit Committee and the Governing Body.

- *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 CCG 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 has carried out an internal audit of the CCG's conflicts of interest management and has concluded an overall opinion of **Significant Assurance**. They have concluded that the CCG's internal policies and procedures are in line with the statutory guidance from NHS England for Managing Conflicts of Interest. They have made a small number of minor recommendations relating to the development of the

Conflicts of Interest Policy for the new merged CCG and checking the allocation of training modules for the new CCG.

Data Quality

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

The CCG requires that reports which are submitted to the Committees and Governing Body clearly set out the detail required and 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 the Data Security & Protection Toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

The CCG continues to make every effort 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. Submission of the 2020-21 Data Security & Protection Toolkit had to be brought forward at short notice as the CCG was working towards merger from April 2020. This required the CCG to submit 3 months ahead of non-merging CCGs, which was a significant challenge. After a substantial effort, the CCG managed to achieve all mandatory assertions and sub-assertions within the Toolkit, and a significant number of non-mandatory assertions/sub-assertions.

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 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, Data Protection Officer and Information Governance lead have been assigned and appropriately trained to fulfil the responsibilities of their role. The CCG have an in-house Information Governance Team shared with Calderdale CCG, North Kirklees CCG, and Wakefield CCG. The 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.

Emergency Preparedness, Resilience and Response

The CCG continues to place a high importance on working with colleagues to ensure appropriate Emergency Preparedness, Resilience and Response..

In March 2020, COVID-19 was declared a pandemic by the World Health Organisation. The CCG escalated its emergency planning and business continuity arrangements including:

- The establishment of an internal command control structure, supported by trained loggists to capture all decisions and actions taken.
- Participation in local, regional and national command and control structures.
- Strengthening of on-call arrangements to facilitate cascade and escalation of information and urgent actions.

These arrangements have been retained throughout 2020-21, reflecting a rapidly evolving situation, with an impact at an unprecedented scale. COVID-19 work dominated the focus of the Governing Body, its committees, and the wider CCG.

The CCG has updated the Governing Body in public session around its arrangements and activities during COVID-19. Additional assurance reports focusing on corporate governance, financial governance, and quality governance have been shared with the Audit Committee on a quarterly basis. At all stages there has been a focus on learning from events.

In August 2020 NHS England issued the statutory requirement which would formally assure them of EPRR readiness within the CCG and the wider NHS. The process was different this year, and the usual approach of the detailed and granular process

of previous years was acknowledged as excessive, especially as the CCG prepared for a further wave of COVID-19, as well as upcoming seasonal pressures and the operational demands of restoring services. The amended process for 2020-21 focused on three areas:

- progress made by organisations that were reported as partially or non-compliant in the 2019-20 process
- the process of capturing and embedding the learning from the first wave of the COVID-19 pandemic
- inclusion of progress and learning in winter planning preparations

The CCG submitted a statement of assurance to the NHS England and NHS Improvement Regional Head of EPRR by 31 October 2020.

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), Leeds Teaching Hospitals Trust (provider of payroll services) and NECS (provider of HR services and review of non-contracted activity). 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 & Contracting Committee and Governing Body receive detailed bi-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.

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 Counter Fraud Authority 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 the NHS Counter Fraud Authority's guidance. This is received and reviewed by the Audit Committee, together with regular updates throughout the year.

Head of Internal Audit Opinion

Audit Yorkshire provide the CCG's internal audit service and 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 executive summary from the Head of Internal Audit's opinion is set out below:

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NHS GREATER HUDDERSFIELD CLINICAL COMMISSIONING GROUP (CCG) FOR THE YEAR ENDED 31 MARCH 2021

This Head of Internal Audit Opinion forms part of the Annual Report for NHS Greater Huddersfield Clinical Commissioning Group in which the planned internal audit coverage and outputs during 2020-21 and Audit Yorkshire's Key Performance Indicators (KPIs) are detailed.

Key Area	Summary
Head of Internal Audit Opinion & the Role of Internal Audit During the Pandemic	The overall opinion for the period 1st April 2020 to 31st March 2021 provides **Significant Assurance**, that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently. The Internal Audit Standards Advisory Board (IASAB) issued guidance regarding conformance with the Public Sector Internal Audit Standards (PSIAS) during the coronavirus pandemic (May 2020). All our work has continued to be delivered in full compliance with the PSIAS. Audit Yorkshire adopted a pragmatic approach to the delivery of your Internal Audit Service during 2020/21, with the focus on the delivery of your Head of Internal Audit Opinion. This again, was in line with the IASAB guidance. We supported you through the provision of a wide range of briefings, updates and benchmarking materials focused on helping you manage the challenges of COVID-19. We also supported the wider NHS systems across Audit Yorkshire's client base / geographies through the redeployment of our staff to maintain the effective delivery of services.
Planned Audit Coverage and Outputs	The 2020-21 Internal Audit Plan has been delivered with the focus on completion of high priority or 'must do' audits to support the provision of a meaningful Head of Internal Audit Opinion. This position has been reported within the progress reports across the financial year. The impact on the organisation of COVID-19 required us to review

Key Area	Summary
	your internal audit risk assessment and plan for 2020-21 on a regular basis, in liaison with yourselves. As part of this assessment we took account of the following: • How the organisation has implemented NHSE/I guidance, issued to support them in responding to COVID-19, whilst still discharging their stewardship responsibilities; • Any revisions to the organisation's strategic priorities as well as liaising with you to review areas for internal audit focus; • Independent assurance requirements on how COVID-19 costs are captured and claimed across a range of areas; and • Mandated review requirements and audits which from a professional internal audit perspective are pre-requisite to ensuring sufficient coverage for a robust Head of Internal Audit Opinion. Therefore review coverage has been focused on: • The organisation's Assurance Framework • Core and mandated reviews, including follow up; and • A range of individual risk based assurance reviews. Due to the impact of the pandemic, there was limited scope to undertake the Quality and Business Development reviews originally included in the plan for 2020-21. These areas will be considered as part of the 2021-22 risk assessment and planning process.
Quality of Service Indicators	The External Quality Assessment, undertaken by CIPFA (2020), provides assurance of Audit Yorkshire's full compliance with the Public Sector Internal Audit Standards.

Helen Kemp-Taylor, Head of Internal Audit

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

The Governing Body Assurance Framework provides me with evidence that the effectiveness of controls that manage risks to the CCG 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, Performance & Contracting and Quality 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 - In line with national guidance the CCG completes a regular self- assessment that is assured by the Audit Committee and submitted to NHS England.
- 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. At the time of writing no significant issues have been reported although the formal assurance reports have not been received as yet.

Conclusion

No significant control issues have been identified.

Carol McKenna, Accountable Officer

11 June 2021

Committee Membership and Attendance Records – 1 April 2020 – 31 March 2021

Please note that committee members regularly send substitutes to meetings when they cannot attend. This attendance record solely records whether they themselves were in attendance. Governing Body and PCCC meetings are split into public and private – these are classed as separate meetings in the below data, to reflect those who only attend part.

Governing Body (15 meetings)	**Attendance**
Dr Steve Ollerton (Chair)	100%
Dr Razwan Ali	100%
Jenny Cullearn	86%
Ian Currell	87%
Alix Ewen (until 12 June)	100%
Beth Hewitt	87%
Carol McKenna	100%
Dr James Morton (until 23 Sept)	67%
Dr Amjid Rehman (from 14 July)	100%
Dr Chunda Sri-Chandana (until 31 Oct)	50%
Hilary Thompson	100%
Penny Woodhead	100%
Martin Wright	100%

Primary Care Commissioning Committee (13 meetings)	**Attendance**
Beth Hewitt (Chair)	100%
Jenny Cullearn (from 1 October)	67%
Ian Currell	92%
Alix Ewen (until 12 June)	100%
Carol McKenna	77%
Dr James Morton (until 23 Sept)	100%
Dr Steve Ollerton	69%
Hilary Thompson	100%
Penny Woodhead	85%
Martin Wright	100%

Audit Committee (5 meetings)	**Attendance**
Martin Wright (Chair)	100%
Dr Chunda Sri-Chandana (until 31 Oct)	50%
Hilary Thompson	100%

Finance, Performance & Contracting Committee (6 meetings)	Attendance
Hilary Thompson (Chair)	100%
Jenny Cullearn	83%
Ian Currell	100%
Carol McKenna	100%
Dr Steve Ollerton	83%
Martin Wright	100%

Remuneration Committee (5 meetings)	Attendance
Hilary Thompson (Chair)	100%
Dr Chunda Sri-Chandana (until 31 Oct)	75%
Martin Wright	80%

Quality Committee (6 meetings)	Attendance
Dr Razwan Ali (Chair)	100%
Alix Ewen (until 12 June)	100%
Beth Hewitt	100%
Carol McKenna	100%
Dr Amjid Rehman (from 14 July)	100%
Dr Chunda Sri-Chandana (until 31 Oct)	100%
Penny Woodhead	67%

West Yorkshire and Harrogate Joint Committee of CCGs' Attendance Record

Organisation and role	Member	Attendance (eligible)
Independent Lay Chair	Marie Burnham	**3** (3)
CCG Lay members		
	Stephen Hardy	**3** (3)
(to 7th July 2020 meeting)	Richard Wilkinson	**1** (1)
(from 6th October 2020 meeting)	Ruby Bhatti	**2** (2)
(from 6th October 2020 meeting)	John Mallalieu	**2** (2)
NHS Bradford, District and Craven CCG		
Clinical Chair	Dr James Thomas	**3** (3)
Chief Officer	Helen Hirst	**2** (3)
Strategic Director of Quality and Nursing	Michelle Thomas *(Deputy for Helen Hirst)*	**1** (1)
NHS Calderdale CCG		
Clinical Chair	Dr Steven Cleasby	**2** (3)
Deputy Chief Officer (to 6th October 2020 meeting)	Neil Smurthwaite	**2** (2)
Chief Officer (from 21st January 2021 meeting)	Robin Tuddenham	**1** (1)
NHS Greater Huddersfield CCG		
Clinical Chair	Dr Steve Ollerton	**3** (3)
NHS North Kirklees CCG		
Clinical Chair	Dr Khalid Naeem	**2** (3)
NHS Greater Huddersfield and North Kirklees CCGs		
Chief Officer	Carol McKenna	**3** (3)
NHS Leeds CCG		
Clinical Chair	Dr Jason Broch	**3** (3)
Chief Executive	Tim Ryley	**3** (3)
NHS Wakefield CCG		
Clinical Chair	Dr Adam Sheppard	**3** (3)
Chief Officer	Jo Webster	**3** (3)
	Associate member	
NHS North Yorkshire CCG		
Clinical Chair	Dr Charles Parker	**2** (3)
Chief Officer	Amanda Bloor	**1** (3)

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

Details of the Remuneration Committee can be found within the Governance Statement (page 66). 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 practitioner (HR service provided by North of England Commissioning Support), the CCG Chief Finance Officer and the CCG Head of Corporate Governance.

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 a review of comparative data across the CCGs and legal advice, are 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.

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

- Pay guidance provided by NHS England;
- Benchmarking with other CCGs;
- Complexity factors;
- Availability of guidance on recruitment and retention premium;
- Prevailing economic climate and local market conditions;
- Any joint management arrangements;
- Performance of the individuals and the CCG.

For the Chief Quality & Nursing Officer, this is driven by Agenda for Change. This post is shared with North Kirklees and Calderdale CCGs, and the post holder is engaged by Greater Huddersfield under a contract of employment. This arrangement is governed by a Memorandum of Understanding between the CCGs.

Remuneration of Very Senior Managers

The CCG is satisfied, on the basis of what it has considered and the factors set out above, that the remuneration received by the clinical chair is reasonable. No senior managers are paid more than £150,000 per annum pro rata.

Senior Manager Remuneration (including salary and pension entitlements)

Name & Title		2020-21 Staff in Post	2020-21					
			Salary (bands of £5,000) £000	Expense payments (taxable) (rounded to the nearest £00) £	Performance pay and bonuses (bands of £5,000) £000	Long-term Performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (Note 5) (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Stephen Ollerton	Clinical Leader	01/04/2020 to 31/03/2021	105 - 110				57.5 - 60	165 - 170
Dr Razwan Ali	Practice Representative	01/04/2020 to 31/03/2021	30 - 35					30 - 35
Dr James Morton	Practice Representative	01/04/2020 to 24/09/2020	15 - 20					15 - 20
Dr Amjid Rehman	Practice Representative	13/07/2020 to 31/03/2021	20 - 25					20 - 25
Alix Ewen	Advanced Nurse Practitioner	01/04/2020 to 12/06/2020	0 - 5					0 - 5
Jenny Cullearn	Practice Representative	01/04/2020 to 31/03/2021	10 - 15					10 - 15
Beth Hewitt	Lay Member - Patient and Public Involvement **(Note 4)**	01/04/2020 to 31/03/2021	10 - 15					10 - 15
Hilary Thompson	Lay Member - Finance and Remuneration **(Note 4)**	01/04/2020 to 31/03/2021	5 - 10					5 - 10
Martin Wright	Lay Member - Audit and Governance **(Note 4)**	01/04/2020 to 31/03/2021	5 - 10					5 - 10
Dr Chunda Sri-Chandana	Secondary Care Advisor	01/04/2020 to 31/10/2020	5 - 10					5 - 10
Carol McKenna	Chief Officer **(Note 1)**	01/04/2020 to 31/03/2021	75 - 80				17.5 - 20	95 - 100
Ian Currell	Chief Finance Officer **(Note 2)**	01/04/2020 to 31/03/2021	65 - 70				15 - 17.5	80 - 85
Penny Woodhead	Chief Quality and Nursing Officer **(Note 3)**	01/04/2020 to 31/03/2021	30 - 35				25 - 27.5	55 - 60

Note 1: Carol McKenna is employed by Greater Huddersfield CCG but is a shared post with North Kirklees CCG, for whom she is also Chief Officer. Her total salary is in the banding £135k - 140k, however only 56% of the cost has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 2: Ian Currell is employed by Greater Huddersfield CCG but is a shared post with North Kirklees CCG, for whom he is also Chief Finance Officer. His total salary is in the banding £115k - 120k, however only 56% of the cost has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 3: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post also with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. Her total salary is in the banding £100k - 105k, however, only 33.33% has been included in the Salary column. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 4: Beth Hewitt, Hilary Thompson and Martin Wright were new Layperson appointments in 19/20. They are employed by Greater Huddersfield CCG but are shared posts with North Kirklees CCG and their costs are split 50:50. Beth Hewitt's total salary is in the banding £20k - 25k, and Hilary Thompson and Martin Wright's salaries are in the banding £15k – 20k, however only 50% of the cost has been included in the Salary column.

Note 5: All Pension Related Benefits represent the annual increase in pension entitlement, and must be disclosed in £2,500 bands. The figures are calculated as follow:

The real increase in pensions multiplied by 20*

Plus: The real increase in any lump sum*

Less: Contributions made by the individual

Equals Accrued pensions benefits

*The real increase is the difference between the annual rate of pension payable to the director at the end of the financial year and the rate payable at the start of the year. It excludes increases due to inflation/decreases due to transfer of pensions rights.

Name & Title		2019-20 Staff in Post	2019-20					
			Salary (bands of £5,000) £000	Expense payments (taxable) (rounded to the nearest £00) £	Performance pay and bonuses (bands of £5,000) £000	Long-term Performance pay and bonuses (bands of £5,000) £000	All Pension Related Benefits (Note 5) (bands of £2,500) £000	Total (bands of £5,000) £000
Dr Stephen Ollerton	Clinical Leader	01/04/2019 to 31/03/2020	95 - 100				15 - 17.5	115 - 120
Dr Jane Ford	Practice Representative	01/04/2019 to 30/09/2019	20 - 25					20 - 25
Dr Dilshad Ashraf	Practice Representative	01/04/2019 to 30/09/2019	15 - 20					15 - 20
Dr Razwan Ali	Practice Representative	01/04/2019 to 31/03/2020	30 - 35					30 - 35
Dr David Hughes	Practice Representative	01/04/2019 to 30/06/2019	5 - 10					5 - 10
Dr James Morton	Practice Representative	01/12/2019 to 31/03/2020	0 - 5					0 - 5
Alix Ewen	Advanced Nurse Practitioner	01/04/2019 to 31/03/2020	10 - 15					10 - 15
Jenny Cullearn	Practice Representative	01/04/2019 to 31/03/2020	10 - 15					10 - 15
Fatima Khan-Shah	Lay Advisor	01/04/2019 to 31/05/2019	0 - 5					0 - 5
Priscilla McGuire	Lay Member - Patient and Public Involvement	01/04/2019 to 31/05/2019	0 - 5					0 - 5
David Longstaff	Lay Member - Audit	01/04/2019 to 31/07/2019	5 - 10					5 - 10
Beth Hewitt	Lay Member - Patient and Public Involvement **(Note 4)**	01/06/2019 to 31/03/2020	5 - 10					5 - 10
Hilary Thompson	Lay Member - Finance and Remuneration **(Note 4)**	01/07/2019 to 31/03/2020	5 - 10					5 - 10
Martin Wright	Lay Member - Audit and Governance **(Note 4)**	01/08/2019 to 31/03/2020	5 - 10					5 - 10
Dr Chunda Sri-Chandana	Secondary Care Advisor	01/04/2019 to 31/03/2020	10 - 15					10 - 15
Angela Monaghan	Nurse Advisor	01/04/2019 to 31/12/2019	5 - 10					5 - 10
Carol McKenna	Chief Officer **(Note 1)**	01/04/2019 to 31/03/2020	75 - 80				45 - 47.5	120 - 125
Ian Currell	Chief Finance Officer **(Note 2)**	01/04/2019 to 31/03/2020	60 - 65				20 - 22.5	85 - 90
Penny Woodhead	Chief Quality and Nursing Officer **(Note 3)**	01/04/2019 to 31/03/2020	30 - 35				22.5 - 25	55 - 60

Pension Benefits as at 31 March 2021

			2020-21						
Name & Title		**2020-21 Staff in Post**	**Real increase in pension at pension age** (bands of £2,500) **£000**	**Real increase in pension lump sum at pension age** (bands of £2,500) **£000**	**Total accrued pension at pension age at 31 March 2021** (bands of £5,000) **£000**	**Lump sum at pension age related to accrued pension at 31 March 2021** (bands of £5,000) **£000**	**Cash Equivalent Transfer Value at 1 April 2020** **£000**	**Real increase in Cash Equivalent Transfer Value** **£000**	**Cash Equivalent Transfer Value at 31 March 2021** **£000**
Dr Stephen Ollerton	Clinical Leader	01/04/2020 to 31/03/2021	2.5 - 5	2.5 - 5	20 - 25	30 - 35	283	41	345
Carol McKenna	Chief Officer **(Note 1)**	01/04/2020 to 31/03/2021	0 - 2.5	- 2.5 - 0	50 - 55	115 - 120	990	24	1051
Ian Currell	Chief Finance Officer **(Note 2)**	01/04/2020 to 31/03/2021	0 - 2.5	- 2.5 - 0	45 - 50	100 - 105	837	20	888
Penny Woodhead	Chief Quality and Nursing Officer **(Note 3)**	01/04/2020 to 31/03/2021	0 - 2.5	0 - 2.5	5 - 10	0 - 5	60	13	88

Note 1: Carol McKenna is employed by Greater Huddersfield CCG but is a shared post with North Kirklees CCG, for whom she is also Chief Officer. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 2: Ian Currell is employed by Greater Huddersfield CCG but is a shared post with North Kirklees CCG, for whom he is also Chief Finance Officer. The above table includes the full pension information, not a proportion in relation to the shared post.

Note 3: Penny Woodhead is employed by Greater Huddersfield CCG but is a shared post with Calderdale CCG and North Kirklees CCG, for whom she is also Chief Quality and Nursing Officer. The above table includes the full pension information, not a proportion in relation to the shared 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.

Note 5: NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a FinalSalary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed

			2019-20						
Name & Title		**2019-20 Staff in Post**	**Real increase in pension at pension age** (bands of £2,500) **£000**	**Real increase in pension lump sum at pension age** (bands of £2,500) **£000**	**Total accrued pension at pension age at 31 March 2020** (bands of £5,000) **£000**	**Lump sum at pension age related to accrued pension at 31 March 2020** (bands of £5,000) **£000**	**Cash Equivalent Transfer Value at 1 April 2019** **£000**	**Real increase in Cash Equivalent Transfer Value** **£000**	**Cash Equivalent Transfer Value at 31 March 2020** **£000**
Dr Stephen Ollerton	Clinical Leader	01/04/2019 to 31/03/2020	0 - 2.5	- 2.5 - 0	15 - 20	30 - 35	254	8	283
Carol McKenna	Chief Officer **(Note 1)**	01/04/2019 to 31/03/2020	2.5 - 5	0 - 2.5	50 - 55	115 - 120	901	48	990
Ian Currell	Chief Finance Officer **(Note 2)**	01/04/2019 to 31/03/2020	0 - 2.5	- 2.5 - 0	45 - 50	100 - 105	777	25	837
Penny Woodhead	Chief Quality and Nursing Officer **(Note 3)**	01/04/2019 to 31/03/2020	0 - 2.5	0 - 2.5	0 - 5	0 - 5	36	11	60

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 that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

There has been no compensation on early retirement or for loss of office.

Payments to past very senior managers

No payments have been made to past very senior managers.

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 Greater Huddersfield CCG in the financial year 2020-21 was £170k - £175k (2019/20: £150k - £155k). This is based on a Full Time Equivalent (FTE) salary. This

was 4.2 times (2019/20: 3.9) the median remuneration of the workforce, which was £40,894 (2019/20: £38,765).

In 2020-21, no employees received remuneration in excess of the highest-paid member of the Governing Body. Remuneration ranged from £21,142 to £171,256 (2019/2020: £18,813 to £152,863).

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

Staff Report

The CCG's workforce profile is shown below and the information is based on the directly employed staff of the CCG as at 28th February 2021. Information relating to the Governing Body is reported separately.

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 (see page 91).

Staff numbers and costs

Average number of people employed as per table below:

This does not include Co-opted members and GB members	**28 February 2021**		
	Permanent employees	**Other**	**Total**
	Number	**Number**	**Number**
Total CCG	89	11	100

The staff costs and employee benefits as at 31st March 2020 are set out as in the tables below:

	ADMIN			PROGRAMME			TOTAL		
	Perm	Other		Perm	Other		Perm	Other	
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	N4A	N4B	N4C	N4D	N4E	N4F	N4G	N4H	N4I
Salaries and wages	2,841	198	3,038	1,333	168	1,501	4,174	366	4,539
Social security costs	307	-	307	139	-	139	446	-	446
Employer contributions to the NHS Pension Scheme	611	-	611	188	-	188	799	-	799
Other pension costs	-	-	-	-	-	-	-	-	-
Apprenticeship Levy	6	-	6	-	-	-	6	-	6
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross Employee Benefits Expenditure	**3,764**	**198**	**3,962**	**1,660**	**168**	**1,828**	**5,424**	**366**	**5,790**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(462)	-	(462)	-	-	-	(462)	-	(462)
Net employee benefits expenditure including capitalised costs	**3,302**	**198**	**3,500**	**1,660**	**168**	**1,828**	**4,963**	**366**	**5,328**
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits expenditure excluding capitalised costs	**3,302**	**198**	**3,500**	**1,660**	**168**	**1,828**	**4,963**	**366**	**5,328**

	31-Mar-20								
	ADMIN			PROGRAMME			TOTAL		
	Perm	Other		Perm	Other		Perm	Other	
	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
	N4J	N4K	N4L	N4M	N4N	N4O	N4P	N4Q	N4R
Salaries and wages	2,747	110	2,858	1,151	299	1,450	3,899	409	4,308
Social security costs	290	-	290	127	-	127	416	-	416
Employer contributions to the NHS Pension Scheme	576	-	576	162	-	162	738	-	738
Other pension costs	-	-	-	-	-	-	-	-	-
Apprenticeship Levy	5	-	5	-	-	-	5	-	5
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	-	-	-	-	-	-	-	-	-
Gross Employee Benefits Expenditure	**3,618**	**110**	**3,728**	**1,440**	**299**	**1,739**	**5,059**	**409**	**5,468**
Less: Recoveries in respect of employee benefits (note 4.1.2)	(374)	-	(374)	(0)	-	(0)	(374)	-	(374)
Net employee benefits expenditure including capitalised costs	**3,244**	**110**	**3,355**	**1,440**	**299**	**1,739**	**4,685**	**409**	**5,094**
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits expenditure excluding capitalised costs	**3,244**	**110**	**3,355**	**1,440**	**299**	**1,739**	**4,685**	**409**	**5,094**

Staff composition

As at 28 February 2021, the CCG directly employed 100 staff (excluding Governing Body, but including the 4 Very Senior Managers (VSM). This equates to 88.81 whole time equivalent (WTE).

Gender profile of the organisation

The following table sets out the gender profile of the organisation as at 31 March 2021.

	Governing Body (excl. Very Senior Managers)	Very Senior Managers (VSM)	Staff Excl. Governing Body and VSMs
Female	3	2	75
Male	3	2	20
Total	**6**	**4**	**95**

Note 1: As an organisation with fewer than 250 employees, the CCG is not required to provide a gender pay report.

Staff turnover percentage

Information about the CCG's staff turnover can be found on the NHS workforce statistics website.

Sickness Absence Data

The CCG has policies and procedures in place to support employees with sickness absence and continues to develop a positive and pro-active approach in supporting employees through sickness absence or difficult periods in their lives. This has been evidenced by reviewing the Managing Sickness Absence Policy in not only aiming to reduce the levels of sickness through improvement plans but providing supporting mechanisms to employees during periods of short and long term sickness.

During 2015, the CCG introduced an Employee Assistance Programme (EAP) to further support the needs of the workforce and this service has been recently reviewed for a further 12 months. The aim of EAP is to help employees deal with personal problems that might adversely impact their work performance, health and well-being. This service provides confidential advice and counselling support to employees which makes available an early source of practical and emotional support for employees facing issues in their home or work life. This is viewed by the CCG as being important in supporting the health and wellbeing of employees.

Throughout the winter period of 2020, the CCG offered workplace flu vaccinations to all its employees, in order to support the resilience of the workforce and the community. The winter flu campaign raised awareness of the benefits of the flu vaccination. The final uptake was 73%. The CCG also commissions a comprehensive Occupational Health service, providing expert advice on the management of health conditions at work.

The CCG is committed to the health and wellbeing of its staff and works hard to promote a healthy working environment. The Staff Forum has been proactive throughout the year in carrying out a number of initiatives.

The CCG engages with its staff through a variety of mechanisms, including an active staff forum, weekly virtual staff briefings, and through a staff intranet, which includes regular news. The CCG participates annually in the national NHS Staff Survey in order to gain staff feedback and understand how the CCG benchmarks against other NHS organisations. 77.3% of staff responded to the survey in 2020. During 2020-21, the CCG has also participated in the monthly NHS People Pulse Survey, introduced nationally to support listening to colleagues during the coronavirus pandemic.

Staff policies

To ensure that CCG staff do not experience discrimination, harassment and victimisation, 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. The CCG's commitment to recruitment, continuing employment, training and career development of disabled people is set out in a number of policies and procedures. These include:

Requirement	Policy or procedure
Giving full and fair consideration to applications for employment by the CCG made by disabled persons, having regard to their particular aptitudes and abilities.	• Equality and Diversity Policy; • Recruitment and Selection Policy.
Continuing the employment of, and arranging appropriate training for, employees of the company who have become disabled persons during the period when they were employed by the company.	• Equality and Diversity Policy; • Managing Sickness Absence Policy; • Flexible Working Policy; • Learning and Development Policy.

Training, career development and promotion of disabled people employed by the company.	• Equality and Diversity Policy; • Recruitment and Selection Policy; • Learning and Development Policy; • Pay Progression Policy; • Appraisal Paperwork.

The CCG has a rolling programme of policy review and awareness raising, as well as the appraisal procedure to further improve the focus on the quality of conversations taking place. The implementation of these policies together with occupational health input supports the continuation of employment and provision of appropriate training to any employee who becomes disabled and ensures access for all CCG employees, including disabled staff members to training, career development and promotion opportunities.

Equality impact assessments have been carried out on all the above policies. Over the past 12 months monitoring has taken place to ensure there has been no detrimental effect with regard to implementation of these workforce policies on CCG staff and to ensure that the CCG have proactively identified and addressed any inequalities.

Trade Union Representation

Good working relationships with trade union representatives are important to us. The main mechanism for this is through our regular Joint Partnership Forum, where HR representatives and CCG senior managers from Calderdale, Greater Huddersfield and North Kirklees CCGs are able to meet with the relevant trade union representatives, to discuss any staff issues or test proposals that might have a direct impact on staff.

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. Under the Regulations, the NHS, including CCGs, must have at least one employee who is a relevant union official, namely a trade union official, a trade union learning representative or a safety representative in accordance with the Health and Safety at Work Act 1974.

Relevant union officials during 2020-21

Total number of employees who were relevant union officials during the period 1 April 2020 – 31 March 2021	2

* Neither of these individuals is directly employed by Greater Huddersfield CCG

The below table contains information on the percentage of their working hours on facility time. For these purposes, facility time is defined as time that is taken off to carry out trade union duties or the duties of a union learning representative, to accompany a worker to a disciplinary or grievance hearing, or to carry out duties and receive training under the relevant safety legislation.

Percentage of time spent on facility time

Percentage of time	**Number of employees**
0%	
1-50%	2
51-99%	
100%	

* Neither of these individuals is employed by Greater Huddersfield CCG

Percentage of pay bill spent on facility time*

Total cost of facility time	£1,493.74
Total pay bill	£15,169,636
% of total pay bill spent on facility time, calculated as: (total cost of facility time / total pay bill) x 100	0.01%

* This is combined annual pay bill for Calderdale, Greater Huddersfield and North Kirklees CCGs

The following table sets out as a percentage of total paid facility time hours, the number of hours spent by employees as union officials during 2019-20, on paid trade union activities.

Paid Trade Union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period / total paid facility time hours) x 100	100%

Disability Confident Employer

In 2016, the government made a commitment to halve the employment gap for disabled people and in order to achieve this it introduced a new Disability Confident scheme. We are extremely proud to say that our CCG was awarded the level 2 Disability Confident Employer badge for 2 years from August 2019. The award is based on us being able to demonstrate that we have:

- Undertaken and successfully completed the Disability Confident self-assessment;
- Are taking all of the core actions to be a Disability Confident employer;
- Are offering at least one activity to get the right people for the business and at least one activity to keeping and developing employees.

As a Disability Confident Employer, we are able to use the logo which lets people know that we have made a commitment regarding recruitment, training, and retention of people with disabilities and the promotion of disability awareness across the organisation. We will continue to work to make this a welcoming and accessible place for people with a disability.

Other employee matters

The CCG is also instrumental in leading other pieces of system-wide work. For instance, providing leadership to work which will support the development of relationships across multi-disciplinary teams, and chairing a group that brings stakeholders together to discuss and agree actions in relation to workforce.

The CCG's approach to human capital management is supported by a robust set of policies and procedures, which underpin the full employee cycle. This includes a fair and transparent approach to recruitment and learning, and a well-embedded appraisal process, to assist individuals and teams with career management in support of the strategic aims of the CCG and the health and care system.

The CCG's approach to pay is included in the remuneration report. With the exception of Very Senior Managers, all staff are engaged under Agenda for Change terms and conditions. There is a clear pay progression policy, ensuring that employees are performing to the standards required in their role, in order to progress up the pay scale.

COVID-19 Related Activities & Support

Employee Assistance Programme

During the pandemic the CCG through its commitment to health and wellbeing jointly with other neighbouring CCGs took out a further EAP contract to support the wider health and social care systems across the locality. The focus of support was on mental health during this time and the need to support wider group of staff and volunteers to access EAP services.

People Pulse survey

In addition to the annual national staff survey the CCG has continued to engage on a monthly basis with staff through the People Pulse survey. The results of the survey to date have been positive and highlighted areas where some support is required for staff. This analysis and support will continue each month to understand trends and themes.

BAME 1-1 Risk Assessments

In response to the growing concerns about the potential disproportionate impact of COVID-19 on Black, Asian and Minority Ethnic (BAME) people, the CCG undertook an exercise of contacting line managers in undertaking individual risk assessments with staff that identified themselves as BAME. All BAME staff received a letter outlining the concerns regarding the emerging evidence of COVID-19 in addition to the work the organisation undertook to ensure individuals feel safe and supported at work through regular conversations. There were no immediate concerns highlighted in the 1-1 conversations and the compliance rate of completion was 100%.

COVID-19 1-1 risk assessments

Current Government guidance is that if possible everyone should work from home. The CCG expects most staff will continue to work from home until further notice, unless there is a significant risk in them doing so. As part of the CCG COVID-19 recovery strategy with the aim of managing the health and wellbeing of staff – all staff have been requested to undertake a risk assessment with the expectation that this will be reviewed on a regular basis should circumstances change. As such 1-1 risk assessments in line with best practice were developed and completed by all staff across the organisation with a compliance rate of 100%.

There have been no concerns highlighted in the 1-1 conversations and control measures have been put in place such as continuing to work from home and regular conversations with managers/teams as part of one's health and wellbeing. A further reminder to staff has been issued on the importance of this.

System Wide Memorandum of Understanding (MOU)

An MOU was developed to support staff in response to COVID-19 pressures and ensuring that there was greater resilience across Calderdale and Kirklees. The purpose of this was for organisations to mutually accept the reciprocal agreement to support the flexible deployment and allocation of staff across system in line with appropriate employment law and governance. In addition, there was a number of CCG staff redeployed to support the wider health and social care system.

Staff Side Meetings/ HR West Yorkshire and North East HR Leads Meetings

In addition to the quarterly Social Partnership Forum meetings, HR has facilitated weekly staff side meetings. By working together in partnership, the CCG has been able to consult and/or discuss on a range of COVID related activity affecting the workforce and the approach to be taken on risk assessments and the continued dialogue associated with these.

HR/CCG management has been networking with the HR leads on a daily/weekly basis in response to COVID-19. The purpose of these additional meetings has been to share learning and ensure there is a consistency in good practice across the CCGs and/or West Yorkshire where applicable. This has proven to be effective in supporting the CCGs during the pandemic with workforce related activity where a quick turnaround was required in line with changing national advice.

Guidance Documentation

There has been a number of guidance documents developed by HR and signposting of resources to deal with workforce issues that have arisen during the pandemic and to support the CCGs in protecting and supporting its workforce. Examples of such guidance has been in relation to annual leave and COVID, non-standard working hours and payment, regular HR FAQ’s and managers guide to remote interviews.

Expenditure on consultancy

In 2020-21, the CCG has spent £43k on consultancy fees.

Off payroll engagements

Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2021, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2021	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

New off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2020 and 31 March 2021, for more than £245 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 2020 and 31 March 2021	0
Of which…	
No. assessed as caught by IR35	0
No. assessed as not caught by IR35	0
No. engaged directly (via PSC contracted to the entity) and are on the departmental payroll	0
No. of engagements reassessed for consistency / assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	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 2020 and 31 March 2021.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year[1]	0

[1] There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

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.[2]	13

[2] As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero

Parliamentary Accountability and 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 2, note 5, note 31 and note 39. An audit certificate and report is also included in this Annual Report at page 147.

NHS
Greater Huddersfield
Clinical Commissioning Group

Annual Accounts

Carol McKenna

Chief Officer

11 June 2021

FOREWORD TO THE ACCOUNTS

NHS GREATER HUDDERSFIELD CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2021 have been prepared by
NHS Greater Huddersfield Clinical Commissioning Group 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 2020-21

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

NHS Greater Huddersfield CCG - Annual Accounts 2020-21

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(1,485)	(2,930)
Other operating income	2	-	-
Total operating income		**(1,485)**	**(2,930)**
Staff costs	4	5,790	5,467
Purchase of goods and services	5	365,385	357,367
Depreciation and impairment charges	5	16	20
Provision expense	5	(182)	284
Other Operating Expenditure	5	1,852	492
Total operating expenditure		**372,861**	**363,630**
Net Operating Expenditure		**371,376**	**360,700**
Finance income		-	-
Finance expense		-	-
Net expenditure for the Year		**371,376**	**360,700**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**371,376**	**360,700**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**371,376**	**360,700**

The notes on pages 5 to 34 form part of this statement

NHS Greater Huddersfield CCG - Annual Accounts 2020-21

Statement of Financial Position as at
31 March 2021

	Note	**2020-21** **£'000**	2019-20 £'000
Non-current assets:			
Property, plant and equipment	13	33	49
Intangible assets	14	-	-
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		33	49
Current assets:			
Inventories	16	-	1,609
Trade and other receivables	17	709	1,157
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	166	132
Total current assets		875	2,898
Non-current assets held for sale	21	-	-
Total current assets		875	2,898
Total assets		908	2,947
Current liabilities			
Trade and other payables	23	(23,230)	(27,617)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	(37)
Total current liabilities		**(23,230)**	(27,654)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(22,322)**	(24,707)
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(173)	(318)
Total non-current liabilities		**(173)**	(318)
Assets less Liabilities		**(22,495)**	(25,025)
Financed by Taxpayers' Equity			
General fund		(22,495)	(25,025)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(22,495)**	(25,025)

The notes on pages 5 to 34 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 9th June 2021
and signed on its behalf by:

Carol McKenna
Chief Accountable Officer
11 June 2021

NHS Greater Huddersfield CCG - Annual Accounts 2020-21

Statement of Changes In Taxpayers Equity for the year ended
31 March 2021

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(25,025)	0	0	**(25,025)**
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 2020	**(25,025)**	**0**	**0**	**(25,025)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(371,376)	0 0	0	**(371,376)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	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 other investments and Financial Assets (excluding available for sale financial assets)			0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(371,376)**	**0**	**0**	**(371,376)**
Net funding	373,906	0	0	**373,906**
Balance at 31 March 2021	**(22,495)**	**0**	**0**	**(22,495)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	(21,695)	0	0	**(21,695)**
Transfer of assets and liabilities from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(21,695)**	**0**	**0**	**(21,695)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20				
Net operating costs for the financial year	(360,700)	0	0	(360,700)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve		0		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(360,700)**	**0**	**0**	**(360,700)**
Net funding	357,370	0	0	357,370
Balance at 31 March 2020	**(25,025)**	**0**	**0**	**(25,025)**

The notes on pages 5 to 34 form part of this statement

NHS Greater Huddersfield CCG - Annual Accounts 2020-21

Statement of Cash Flows for the year ended
31 March 2021

	Note	**2020-21** **£'000**	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(371,375)	(360,700)
Depreciation and amortisation	5	16	20
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		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		1,609	176
(Increase)/decrease in trade & other receivables	17	447	477
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(4,387)	2,517
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	0	0
Increase/(decrease) in provisions	30	(182)	284
Net Cash Inflow (Outflow) from Operating Activities		**(373,872)**	(357,226)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(49)
(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
Non-cash movements arising on application of new accounting standards		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		**0**	(49)
Net Cash Inflow (Outflow) before Financing		**(373,872)**	(357,275)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		373,906	357,370
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
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**373,906**	357,370
Net Increase (Decrease) in Cash & Cash Equivalents	20	**34**	95
Cash & Cash Equivalents at the Beginning of the Financial Year		**132**	37
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		**166**	132

The notes on pages 5 to 34 form part of this statement

NHS Greater Huddersfield CCG - Annual Accounts 2020-21

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 and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. 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 a going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

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

Greater Huddersfield CCG ceased operations on 1 April 2021 and it services were transferred to the new Kirklees CCG from that date.

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 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Gorup are outside the scope of IFRS 3 BusinessCombinations. Where fundtions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of apsorption accounting. 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 and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The clinical commissioning group has entered into three pooled budget arrangement with [Kirklees Metropolitan Council and NHS North Kirklees Clinical Commissioning Group in accordance with section 75 of the NHS Act 2006. Under the arrangement, funds are pooled for 1/ Community Equipment Service 2/ Better Care Fund and 3/ Healthy Child Programme and Note 35 to the accounts provides details of the income and expenditure.

The three pooled arrangements are hosted by Kirklees Metropolitan Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 Revenue

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
• As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are standard reflecting cross government principles.
The value of the benefit received when the clinical commissioning group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, 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.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Local Government Pensions

Some employees are members of the Local Government Pension Scheme (LGPS), 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 interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. The interest earned during the year from scheme assets is recognised within finance income. Re-measurements of the defined benefit plan are recognised in the Income and Expenditure reserve and reported as an item of other comprehensive income / net expenditure.

1.8 **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.

1.9 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 **Property, Plant & Equipment**

1.10.1 **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.

1.10.2 **Measurement**

All property, plant and equipment is 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.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
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. Current values in existing use are determined as follows:

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

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.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, 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.

1.10.3 **Subsequent Expenditure**

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

1.11 **Intangible Assets**

1.11.1 **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.

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.

1.11.2 **Measurement**

Intangible assets acquired separately are intially recognised at cost. 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.

Notes to the financial statements

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 amortised 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. Revaluations and impairments are treated in the same manner as for property, plant and equipment.

1.11.3 **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 the shorter of the lease term and the estimated useful life, unless NHS Greater Huddersfield CCG expects to acquire the asset at the end of the lease term, in which case the asset is depreciated in the same manner as for owned assets.

At each reporting period end, the clinical commissioning group checks whether there is any indication that any of its property, plant and equipment assets 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.

1.12 **Donated Assets**

Donated non-current assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.13 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.14 **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.

1.15 **Leases**

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

1.15.1 **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 the Statement of Comprehensive Net Expenditure.

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.

1.15.2 **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.

1.15.3 **The Clinical Commissioning Group reclassification of Lease**

The CCG had commenced the assessment of the application of IFRS 16 to its financial statements during financial year 2019/20, and re-categorised treatment of these costs during this financial year. This work was to identify leases which are currently operating leases and should be reclassified as finance leases as well as a broader review of recurring expenditure streams where right to use assets may be embedded in contracting arrangements. The work had progressed to March 2020, when the CCG revised it operational priorities and working patterns to deal with the COVID19 pandemic and combined with the decision to deter the implementation of IFRS16 in the NHS to 1 April 2022. The CCG will recommence during Autumn 2021.

1.16 **Private Finance Initiative Transactions**

PFI transactions that meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability.
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
• repayment of the finance lease liability, including finance costs, and

• payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

1.16.1 **Services Received**

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

1.16.2 **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 current value in existing use.

1.16.3 **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.

The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

1.16.4 **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 cost.
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.

1.16.5 **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.

1.16.6 **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, the difference between the fair value of the asset and the initial value of the liability is recognised as deferred income, representing the future service potential to be received by NHS Greater Huddersfield CCG through the asset being made available to third party users. The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.17 **Inventories**

Inventories are valued at the lower of cost and net realisable value. A change in accounting treatment has taken place this year to expense community stock in full, in line with the Clinical Commissioning Groups Local Authority partners, Kirklees Metropolitan Borough Council.

1.18 **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.
Cash, bank and overdraft balances are recorded at current values.

1.19 **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:

Early retirement provisions are discounted using HM Treasury’s pension discount rate of **negative 0.95% (2019-20: negative 0.5%)** in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of -0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
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.

1.20 **Clinical Negligence Costs**

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

1.21 **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 Resolution 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.

1.22 **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.

1.23 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme was a mandatory cap and trade scheme for non-transport CO2 emissions. The scheme was closed on 31st March 2019. NHS Greater Huddersfield was registered with the Carbon Commitment Reduction scheme, and was therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. Allowances acquired under the scheme were recognised as intangible assets.

1.24 **Contingent liabilities and contingent assets**

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, contingent liabilities and contingent assets are disclosed at their present value.

1.25 **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 and NHS Greater Huddersfield CCG has transferred substantially all of the risks and rewards of ownership or has not retained control of the asset. Financial assets are initially recognised at fair value plus or minus directly attributable transaction costs for financial assets not measured at fair value through profit or loss. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices, where possible, or by valuation techniques.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.25.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.25.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.25.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.25.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.
The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.26 **Financial Liabilities**

Notes to the financial statements

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.

1.26.1 **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.

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

Derivatives that are liabilities are subsequently measured at fair value through profit or loss. Embedded derivatives that are not part of a hybrid contract containing a host that is an asset within the scope of IFRS 9 are separately accounted for as derivatives only if their economic characteristics and risks are not closely related to those of their host contracts, a separate instrument with the same terms would meet the definition of a derivative, and the hybrid contract is not itself measured at fair value through profit or loss.

1.26.3 **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 and Social Care, 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.

1.27 **Value Added Tax**

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

1.28 **Foreign Currencies**

The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. 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.

1.29 **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.

1.30 **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).

1.31 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.31.1 **Critical accounting judgements in applying accounting policies**

There are no judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies.

1.31.2 **Sources of estimation uncertainty**

The Clinical Commissioning Group has made an estimate for prescribing accrual based on the latest available NHS Business Service Authority information.

1.32 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2022/23, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.
● IFRS 16 Leases – The Standard is effective 1 April 2022 as adapted and interpreted by the FReM.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

1.34 **Roundings**

Small rounding adjustments have been made in these published accounts for the Clinical Commissioning Group.

2 Other Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	-	10
Non-patient care services to other bodies	758	2,501
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Income generation	-	-
Other Contract income	265	45
Recoveries in respect of employee benefits	462	374
Total Income from sale of goods and services	**1,485**	**2,930**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**-**	-
Other non contract revenue	**-**	-
Total Other operating income	**-**	**-**
Total Operating Income	**1,485**	**2,930**

2.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	-	758	-	-	-	-	180	428
Non NHS	-	-	-	-	-	-	85	34
Total	**-**	**758**	**-**	**-**	**-**	**-**	**265**	**462**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	-	758	-	-	-	-	265	462
Over time	-	-	-	-	-	-	-	-
Total	**-**	**758**	**-**	**-**	**-**	**-**	**265**	**462**

3 Revenue

	2020-21 Total £'000	2019-20 Total £'000
From rendering of services	1,485	2,930
From sale of goods	-	-
Total	**1,485**	**2,930**

Revenue is totally from the supply of services. The Clinical Commissioning Group received no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		2020-21
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	4,173	366	4,539
Social security costs	446	-	446
Employer Contributions to NHS Pension scheme	799	-	799
Other pension costs	-	-	-
Apprenticeship Levy	6	-	6
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	5,424	366	5,790
Less recoveries in respect of employee benefits (note 4.1.2)	(462)	-	(462)
Total - Net admin employee benefits including capitalised costs	4,962	366	5,328
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	4,962	366	5,328

4.1.1 Employee benefits

	Total		2019-20
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	3,899	409	4,308
Social security costs	416	-	416
Employer Contributions to NHS Pension scheme	738	-	738
Other pension costs	-	-	-
Apprenticeship Levy	5	-	5
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	5,058	409	5,467
Less recoveries in respect of employee benefits (note 4.1.2)	(374)	-	(374)
Total - Net admin employee benefits including capitalised costs	4,684	409	5,093
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	4,684	409	5,093

4.1.2 Recoveries in respect of employee benefits

			2020-21	2019-20
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(372)	-	(372)	(307)
Social security costs	(42)	-	(42)	(34)
Employer contributions to the NHS Pension Scheme	(48)	-	(48)	(33)
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Total recoveries in respect of employee benefits	(462)	-	(462)	(374)

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**92.38**	**3.68**	**96.06**	**87.50**	**4.44**	**91.94**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Staff sickness absence and ill health retirements

This note has been removed from the accounts and is now included in the Annual Report.

4.4 Exit packages agreed in the financial year

There have been no exit packages agreed during financial year 2020-21.

4.5 Pension costs

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

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

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.
The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,285	918
Services from foundation trusts	174,853	171,966
Services from other NHS trusts	25,647	24,299
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	-
Purchase of healthcare from non-NHS bodies	83,858	84,599
Purchase of social care	-	-
General Dental services and personal dental services	-	-
Prescribing costs	38,613	36,841
Pharmaceutical services	133	-
General Ophthalmic services	266	398
GPMS/APMS and PCTMS	38,173	35,072
Supplies and services – clinical	281	365
Supplies and services – general	416	137
Consultancy services	43	254
Establishment	740	943
Transport	(1)	5
Premises	899	1,008
Audit fees	60	49
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	24	9
Other professional fees	35	398
Legal fees	61	87
Education, training and conferences	(1)	19
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	-	-
Total Purchase of goods and services	**365,385**	**357,367**
Depreciation and impairment charges		
Depreciation	16	20
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**16**	**20**
Provision expense		
Change in discount rate	-	-
Provisions	(182)	284
Total Provision expense	**(182)**	**284**
Other Operating Expenditure		
Chair and Non Executive Members	182	383
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	36	33
Expected credit loss / (gain) on receivables	(3)	5
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	1,609 *	-
Other expenditure	28	71
Total Other Operating Expenditure	**1,852**	**492**
Total operating expenditure	**367,071**	**358,163**

* During the current financial year the CCG changed its accounting treatment of stock to show as an expense in line with its Local Authority partners, Kirklees Metropolitan Borough Council.

6.1 Better Payment Practice Code

Measure of compliance	2020-21 Number	2020-21 £'000	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	4,234	94,954	4,598	93,850
Total Non-NHS Trade Invoices paid within target	4,094	92,505	4,401	91,532
Percentage of Non-NHS Trade invoices paid within target	**96.69%**	**97.42%**	**95.72%**	**97.53%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,085	243,202	2,882	228,072
Total NHS Trade Invoices Paid within target	1,060	242,848	2,779	224,833
Percentage of NHS Trade Invoices paid within target	**97.70%**	**99.85%**	**96.43%**	**98.58%**

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

The Clinical Commissioning Group has not made any payments under this legislation.

7 Income Generation Activities

The Clinical Commissioning Group does not undertake income generation activities.

8 Investment Revenue

The Clinical Commissioning Group has had no investment revenue during the period.

9 Other gains and losses

The Clinical Commissioning Group has had no other gains and losses.

10 Finance Costs

The Clinical Commissioning Group has had no finance costs during the period.

11 Net gain / (loss) on transfer by absorption

The Clinical Commissioning Group has had 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

	2020-21				2019-20			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	49	15	**64**	-	43	18	**61**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**49**	**15**	**64**	**-**	**43**	**18**	**61**

12.1.2 Future minimum lease payments

	2020-21				2019-20			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	-	51	15	**66**	-	69	18	**87**
Between one and five years	-	153	15	**168**	-	246	36	**282**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**204**	**30**	**234**	**-**	**315**	**54**	**369**

13 Property, plant and equipment

2020-21	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 2020	-	-	-	-	-	-	72	-	72
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	-	-	-
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**72**	**-**	**72**
Depreciation 01 April 2020	-	-	-	-	-	-	23	-	23
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	16	-	16
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**39**	**-**	**39**
Net Book Value at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**33**	**-**	**33**
Purchased	-	-	-	-	-	-	33	-	33
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**33**	**-**	**33**
Asset financing:									
Owned	-	-	-	-	-	-	33	-	33
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**33**	**-**	**33**

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 2021.

13.2 Donated assets

The Clinical Commissioning Group has no donated assets as at 31st March 2021.

13.3 Government granted assets

The Clinical Commissioning Group has no government granted assets as at 31st March 2021.

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 2021.

13.8 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2020-21 £'000	2019-20 £'000
Land	-	-
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	23	23
Furniture & fittings	-	-
Total	**23**	**23**

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 current assets as at 31st March 2021.

14.1 Donated assets

The Clinical Commissioning Group has no donated assets as at 31st March 2021.

14.2 Government granted assets

The Clinical Commissioning Group has no government granted assets as at 31st March 2021.

14.3 Revaluation

The Clinical Commissioning Group has no revalued assets as at 31st March 2021.

14.4 Compensation from third parties

The Clinical Commissioning Group has not received any compensation from third parties as at 31st March 2021.

14.5 Write downs to recoverable amount

The Clinical Commissioning Group has had no write downs to recoverable amount as at 31st March 2021.

14.6 Non-capitalised assets

The Clinical Commissioning Group has no non-capitalised assets as at 31st March 2021.

14.7 Temporarily idle assets

The Clinical Commissioning Group has no temporary idle assets as at 31st March 2021.

14.8 Cost or valuation of fully amortised assets

The Clinical Commissioning Group has no fully amortised assets as at 31st March 2021.

15 Investment property

The Clinical Commissioning Group has no investment property as at 31st March 2021.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2020	-	-	-	-	-	1,609	**1,609**
Additions	-	-	-	-	-	-	**-**
Inventories recognised as an expense in the period	-	-	-	-	-	(1,609)	**(1,609)**
Write-down of inventories (including losses)	-	-	-	-	-	-	**-**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	**-**
Transfer (to) from -Goods for resale	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**

During the current financial year the CCG changed its accounting treatment of stock to show as an expense in line with its Local Authority partners, Kirklees Metropolitan Borough Council.

17.1 Trade and other receivables

	Current 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	436	-	809	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	4	-	-	-
NHS accrued income	-	-	93	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	59	-	131	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	49	-	41	-
Non-NHS and Other WGA accrued income	154	-	39	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	(5)	-
VAT	7	-	49	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	-	-	-	-
Total Trade & other receivables	**709**	**-**	**1,157**	**-**
Total current and non current	**709**		**1,157**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	2020-21 Non DHSC Group Bodies £'000	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	436	53	801	123
By three to six months	-	-	8	2
By more than six months	-	8	-	5
Total	**436**	**61**	**809**	**130**

£364k of the above amount has been subsequently recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31st March 2021.

17.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(4)	-	**(4)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	2	-	**2**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	2	-	**2**
Total	**(0)**	**-**	**(0)**

18 Other financial assets

The Clinical Commissioning Group has no other financial assets as at 31st March 2021.

19 Other current assets

The Clinical Commissioning Group has no other current assets as at 31st March 2021.

20 Cash and cash equivalents

	2020-21 £'000	2019-20 £'000
Balance at 01 April 2020	132	37
Net change in year	34	95
Balance at 31 March 2021	**166**	**132**
Made up of:		
Cash with the Government Banking Service	166	132
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**166**	**132**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2021	**166**	**132**

The Clinical Commissioning Group does not hold patients monies.

21 Non-current assets held for sale

The Clinical Commissioning Group does not have any non current assets held for sale.

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 2020-21 £'000	Non-current 2020-21 £'000	Current 2019-20 £'000	Non-current 2019-20 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	98	-	1,448	-
NHS payables: Capital	-	-	-	-
NHS accruals	337	-	3,766	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	1,158	-	1,469	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	21,155	-	20,186	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	68	-	59	-
VAT	-	-	-	-
Tax	52	-	48	-
Payments received on account	-	-	-	-
Other payables and accruals	362	-	640	-
Total Trade & Other Payables	**23,230**	**-**	**27,616**	**-**
Total current and non-current	**23,230**		**27,616**	

Other payables include £272k outstanding GP and CCG pension contributions at 31 March 2021 (2019-20 £243k GP and Clinical Commissioning Group).

24 Other financial liabilities

The Clinical Commissioning Group has no financial liabilities as at 31st March 2021.

25 Other liabilities

The Clinical Commissioning Group has no other liabilities as at 31st March 2021.

26 Borrowings

The Clinical Commissioning Group has no borrowings as at 31st March 2021.

27 Private finance initiative, LIFT and other service concession arrangements

The Clinical Commissioning Group has no private finance initiative, LIFT or service concession arrangements as at 31st March 2021.

28 Finance lease obligations

The Clinical Commissioning Group has no finance lease obligations as at 31st March 2021.

29 Finance lease receivables

The Clinical Commissioning Group has no finance lease receivables as at 31st March 2021.

30 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	37	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	-	-	-	-
Other	-	173	-	318
Total	**-**	**173**	**37**	**318**
Total current and non-current	**173**		**355**	

	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 2020	**-**	**-**	**-**	**37**	**-**	**-**	**-**	**-**	**318**	**355**
Arising during the year	-	-	-	-	-	-	-	-	-	**-**
Utilised during the year	-	-	-	-	-	-	-	-	-	**-**
Reversed unused	-	-	-	(37)	-	-	-	-	(145)	**(182)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**173**	**173**
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	-	-	**-**
Between one and five years	-	-	-	-	-	-	-	-	173	**173**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2021	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**173**	**173**

The other non current provision is in respect of VAT risk on outsourced business intelligence VAT risk of £173k.

The CCG has written down its provisions in respect of GP Federation VAT and potential redundancy costs as these items are no longer considered a probable risk.

Under the Accounts Directions issued by NHS England, on 12 February 2014, NHS England has the responsibility for accounting of liabilities relating to NHS Continuing Healthcare claims prior to the formation of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group and the total value of the legacy relating to the provision at 31 March 2021 is £71k (31 March 2020 £73k).

31 Contingencies

The Clinical Commissioning Group has no contingent assets or liabilities.

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group has no outstanding capital commitments as at 31st March 2021.

32.2 Other financial commitments

The Clinical Commissioning Group has not entered into any non cancellable contracts as at 31st March 2021.

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 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 revenue comes through 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.

33.1.4 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.

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	428		428
Trade and other receivables with other DHSC group bodies	160		160
Trade and other receivables with external bodies	61		61
Other financial assets	-		-
Cash and cash equivalents	165		165
Total at 31 March 2021	**814**	**-**	**814**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	124		**124**
Trade and other payables with other DHSC group bodies	8,780		**8,780**
Trade and other payables with external bodies	14,206		**14,206**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2021	**23,110**	**-**	**23,110**

33.4 Maturity of Financial Liabilities

	Payable to DH 2020-21 £'000	Payable to Other Bodies 2020-21 £'000	Total 2020-21 £'000
In one year or less	435	22,675	23,110
In more than one year but not more than two years	-	-	-
In more than two years but not more than five years	-	-	-
In more than five years	-	-	-
Total at 31 March 2021	**435**	**22,675**	**23,110**

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 2021.

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
Commissioning Of Healthcare Services	372,861	(1,485)	**371,376**	908	(23,403)	**(22,495)**
Total	**372,861**	**(1,485)**	**371,376**	**908**	**(23,403)**	**(22,495)**

34.1 Reconciliation between Operating Segments and SoCNE

	2020-21 £'000
Total net expenditure reported for operating segments	371,376
Total net expenditure per the Statement of Comprehensive Net Expenditure	371,376

34.2 Reconciliation between Operating Segments and SoFP

	2020-21 £'000
Total assets reported for operating segments	908
Total assets per Statement of Financial Position	**908**

	2020-21 £'000
Total liabilities reported for operating segments	(23,403)
Total liabilities per Statement of Financial Position	**(23,403)**

35 Joint arrangements - interests in joint operations

CCGs should disclose information in relation to joint arangements in line with the requirements in IFRS 12 - Disclosure of interests in other entities.

35.1 Interests in joint operations

			Amounts recognised in Entities books ONLY 2020-21				Amounts recognised in Entities books ONLY 2019-20			
Name of arrangement	Parties to the arrangement	Description of principal activities	Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Better Care Fund	North Kirklees Clinical Commissioning Group	Pooled Better Care Fund (including Community Equipment Service)	0	0	13,673	5,063	0	0	12,878	4,684
Better Care Fund	Greater Huddersfield Clinical Commissioning Group	Pooled Better Care Fund (including Community Equipment Service)	0	0	16,958	6,695	0	0	15,966	6,198
Better Care Fund	Kirklees Metropolitan Council	Pooled Better Care Fund (including Community Equipment Service)	863	0	25,041	43,914	804	0	24,649	42,611
Healthy Child Programme	North Kirklees Clinical Commissioning Group	Pooled Childrens Services	0	0	1,454	1,454	0	0	1,454	1,454
Healthy Child Programme	Greater Huddersfield Clinical Commissioning Group	Pooled Childrens Services	0	0	1,860	1,860	0	0	1,860	1,860
Healthy Child Programme	Kirklees Metropolitan Council	Pooled Childrens Services	0	0	7,943	7,943	0	0	7,943	7,943

As part of the pooled budget agreement for community equipment service within the better care fund, the Clinical Commissioning Group recognises £863k reserve held by Kirklees Metropolitan Council.

The Better Care Fund pool for financial year 2020-21 is made up of contributions for health related schemes and social care schemes. For the purposes of this note, the Clinical Commissioning Group have only recognised expenditure on health related schemes.

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The Clinical Commissioning Group has no interests in entities which have not been accounted for under IFRS 10 and IFRS 11 for year ended 31 March 2021.

36 NHS Lift investments

The Clinical Commissioning Group has no LIFT investments.

37 Related party transactions

Representatives from the GP practices below were members of our Governing Body during 2020-21 and/or 2019-20. Their practices received remuneration from the Clinical Commissioning Group for services to patients. The amounts involved are disclosed below. The remuneration of individual Executive Governing Body members is disclosed within the Clinical Commissioning Group's Remuneration Report section of the Annual Report.

Details of related party transactions with individuals are as follows:

	Payments to Related Party 2019-20 £000	**Receipts from Related Party 2019-20 £000**	**Amounts owed to Related Party 2019-20 £000**	**Amounts due from Related Party 2019-20 £000**	Payments to Related Party 2019-20 £000	Receipts from Related Party 2019-20 £000	Amounts owed to Related Party 2019-20 £000	Amounts due from Related Party 2019-20 £000
Elmwood (Dr James Morton)	2,629	0	154	0	2,494	0	193	0
Lindley Group (Dr Matt Kaye - left)	0	0	0	0	0	0	0	0
The Grange (Dr Jane Ford - left))	0	0	0	0	2,187	0	118	0
Meltham Group (Dr Dilshad Ashraf - left)	0	0	0	0	883	0	29	0
Netherton (Dr Chris Beith - left)	0	0	0	0	0	0	0	0
Skelmanthorpe (Dr Steve Ollerton, Amjid Rehman)	1,463	0	24	0	1,248	0	52	0
University Health Centre (Alix Ewen)	2,343	0	110	0	1,981	0	142	0
Junction Surgery (Dr Razwan Ali)	891	0	28	0	786	0	25	0
Newsome (Amjid Rehman)	854	0	24	0	0	0	0	0

Payments to related parties include invoices paid totalling £8,180k and amounts owed of £339k.

The Governing Body members have no material related party transactions in 2020-21.

All 37 GP Practices are members and have shares in My Health Huddersfield Limited.

Related party transactions in relation to the GP Federation My Health Huddersfield totalling £401k in 2020-21, of which a balance of £0k was owed at 31st March 2021.

Dr James Morton is a practice representatives from Elmwood Health Centre which is the designated payee for The Valleys Primary Care Network payments.
Elmwood Health Centre attracted income in relation to The Valleys Primary Care Network of £407k in 2020-21, of which a balance of £71k was owed at 31st March 2021.

Alix Ewen is a practice representative from The University Health Centre which is the designated payee for Tolson Primary Care Network payments.
The University Health Centre attracted income in relation to Tolson Primary Care Network of £504k in 2020-21, of which a balance of £55k was owed at 31st March 2021.

Dr Steve Ollerton is a practice representatives from Skelmanthorpe Family Doctors, which became the designated payee for The Mast Primary Care Network.
Through Skelmanthorpe the Mast Primary Care Network attracted income of £318k in 2020-21, of which a balance of £28k was owed at 31st March 2021, further income of £161k had previously passed through Dearne Valley Health Centre for the network

Dr Razwan Ali is a practice representative from The Junction Surgery, which has a relationship with Tolson Primary Care Network.
Tolson Primary Care Network attracted income of £504k in 2020-21, of which a balance of £55k was owed at 31st March 2021.

Viaduct Health & Care Network attracted income of £546k in 2020-21, of which a balance of £4k was owed at 31st March 2021.

Greenwood Network attracted income of £620k in 2020-21, of which a balance of £121k was owed at 31st March 2021.

The parent entity for the Clinical Commissioning Group 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:

	2020-21 £000	2019-20 £000
Calderdale & Huddersfield NHS Foundation Trust	137,455	133,246
Prescription Pricing Authority	37,122	35,846
South West Yorkshire Partnership NHS Foundation Trust	26,344	25,342
Yorkshire Ambulance Service NHS Trust	14,859	12,906
Leeds Teaching Hospitals NHS Trust	8,056	8,107
Barnsley Hospital NHS Foundation Trust	7,158	6,960
Mid Yorkshire Hospitals NHS Trust	2,637	2,578
Bradford Teaching Hospitals NHS Foundation Trust	2,652	2,530
Sheffield Teaching Hospitals NHS Foundation Trust	1,018	1,056
NHS North of England CSU	900	284

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

	2020-21 £000	2019-20 £000
Kirklees Metropolitan Council	21,576	16,511

38 Events after the end of the reporting period

From the 31st March 2021, Greater Huddersfield CCG will cease operation in its current form. The CCG will form part of the new Kirklees CCG from the 1st April 2021.

39 Losses and Special Payments

	2020-21 Total Number of Cases Number	2020-21 Total Value of Cases £'000
Administrative write-offs	1	2
Fruitless payments	-	-
Store losses	-	-
Book Keeping	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Total	**1**	**2**

No special payments were made in the year to 31st March 2021.

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:

	2020-21 Target	2020-21 Performance	2019-20 Target	2019-20 Performance
Expenditure not to exceed income	373,612	372,861	364,682	363,680
Capital resource use does not exceed the amount specified in Directions	-	-	50	49
Revenue resource use does not exceed the amount specified in Directions	372,126	371,375	361,702	360,701
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	4,836	4,466	5,526	4,926

In 2020-21 the Clinical Commissioning Group received revenue resource allocations totalling £372,126k and had net expenditure of £371,375k delivering an in-year surplus of £751k.

42 Impact of IFRS

There has been no impact to the Clinical Commissioning Group in relation to changes to IFRS during the financial year.

43 Analysis of charitable reserves

The Clinical Commissioning Group has no charitable reserves as at 31st March 2021.

Report by the Auditors to Members of the CCG

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS KIRKLEES CLINICAL COMMISSIONING GROUP IN RESPECT OF NHS GREATER HUDDERSFIELD CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Greater Huddersfield Clinical Commissioning Group ("the CCG") for the year ended 31 March 2021 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Emphasis of matter - going concern basis of preparation

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 April 2021, NHS Greater Huddersfield Clinical Commissioning Group was dissolved and its services were transferred to the newly formed NHS Kirklees Clinical Commissioning Group. Under the continuation of service principle NHS Greater Huddersfield Clinical Commissioning Group is a going concern and the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor CCG. Our opinion is not modified in respect of this matter.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management and the Audit Committee, review of Internal Audit reports through the year including Counter Fraud reports to Audit Committee and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as accruals.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journal entries posted at the end of the financial year or as post-closing entries which reduced expenditure that were considered outside of the normal course of business and other unusual journal characteristics.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the completeness and accuracy of recorded expenditure through specific testing over the purchase of healthcare from non-NHS bodies and Non-NHS accruals during periods 12 and 13.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under the NHS Act 2006, as amended by paragraph 223I1 (3) of Section 27 of the Health and Social Care Act 2012, the CCG must ensure that its revenue resource allocation in any financial year does not exceed the amount specified by NHS England. Expenditure in excess of the amount specified is unlawful.

We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 59, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

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

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 59, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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.

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 the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England 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.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Kirklees CCG, as a body, in respect of NHS Greater Huddersfield CCG, 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, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Greater Huddersfield CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

James Boyle
for and on behalf of KPMG LLP,
Chartered Accountants
1, St. Peter's Square
Manchester
M2 3AE

16 June 2021