Barnsley Clinical Commissioning Group

Putting Barnsley People First

NHS Barnsley CCG Annual Report and Accounts 2014 – 2015

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1. Welcome by Chair and Chief Officer

Welcome to our second Annual Report & Accounts for the year 2014-15. Clinical commissioning groups (CCGs) are empowered to make decisions about local NHS services. NHS Barnsley CCG is led by local doctors and elected members; lay members; a specialist consultant and nurse; and a practice manager member, all of whom are close to patients and their needs. We believe that this enables us to improve the quality of care provided to all the people of Barnsley. We are supported by a very experienced team of NHS professionals.

As you will read in this document, you will see that we have faced some significant challenges, but we have also achieved much in our second year. We are particularly proud of the innovative work that we have initiated to develop services which are more integrated and will provide more personalised care for patients. We have been recognised nationally for our plans and have attracted additional funding for the borough.

However, we recognise that there is still much to do. The demand for services is growing and together with our partners we recognise that there still needs to be a significant shift in the way services work better together, making it easier and more effective for patients. In a period of restraint in public spending the CCG has to ensure it makes best use of the public money it is accountable for, which means there are difficult decisions for us to ensure we deliver the best for patients and fulfil our statutory duty to keep within our budget.

Whilst it is appropriate that clinicians drive improvements in the NHS, we cannot do this without first involving and engaging our patients and partner organisations. We have worked to build relationships between all parts of the health and social care system and to encourage a collective “system wide” approach to the issues we face.

We have spent a considerable amount of time working with Barnsley Hospital to address the issues raised by their regulator Monitor. The turnaround in A&E performance within year is a tremendous achievement. Our focus on ambulance waiting times for the most critically ill Barnsley patients has grown pace and will continue into the coming year.

We have already undertaken an extensive programme of engagement as you will read in the report.

We need to hear from and understand the diverse needs and aspirations of everyone across the borough and so will continue to expand our engagement activities. We will be inclusive and open, as we have demonstrated through taking our Governing Body meetings out and about to different venues across the borough. We extend our thanks to those organisations such as Darton College , where staff and students offered us a warm welcome and took

the opportunity to ask us questions on the services we commission. We have also worked closely with Healthwatch and Barnsley Deaf Forum this year, something we aim to continue. Together we can work for a quality-led, efficient and effective NHS.

This Annual Report & Accounts outlines some of our challenges and achievements. We particularly want to record our thanks to our dedicated staff in the CCG and those in our member practices and partner organisations, for their incredibly hard work over this year.

We look forward to continuing our journey together over the coming year.

Dr Nick Balac, Chair

Lesley Smith, Chief Officer

2. Member practices introduction

2.1. Reflections on the CCG's progress and performance

NHS Barnsley Clinical Commissioning Group (CCG) is made up of 36 member GP practices from across the length and breadth of the Barnsley borough, representing approximately 244,000 patients.

From April 1st 2013, it became the responsibility of our GP practices to set the healthcare commissioning priorities for the year ahead. As a Membership Council, we have elected members to the Governing Body to manage complex budgets, plan, buy and monitor healthcare services with and for the people of Barnsley.

Guided by a clear vision, values and an understanding of local health needs, we have developed strategies which will ensure high quality and sustainable health care by putting the people of Barnsley first.

As our second year as a statutory body, 2014-15 was a year of innovation, pace of progress and improved health outcomes for Barnsley people. A number of complex programmes of work were developed and launched during the year putting patients, families, and carers at the heart of care and integrating health and care services to support that.

2.2. Our impact

Our key achievements throughout the year have included:

- The launch of **RightCare Barnsley** – an alliance of our local hospital and community health providers to provide a nurse-led team offering a single point of contact for GPs to call when a patient may require a hospital admission within a 24-hour period. With the RightCare Barnsley team co-ordinating the services this way, it means that **patients receive the right care, in the right place, at the right time** and can avoid going to hospital when it is not needed

- We have worked closely with our local hospital to understand and **reduce the high numbers of people attending A&E**, particularly those people who could have used another service, such as a GP or Pharmacist. The **research we commissioned** has helped us understand those things which affect people's behaviour and choice of service. The work in Barnsley has been recognised in national health magazines

- Like many areas across the country over the past year, the number of patients that come to our local A&E who are very seriously ill and need to be admitted into hospital has remained high. This has been a challenging year for all A&E departments

yet despite this, the number of people being seen within four hours in **Barnsley A&E has improved** and 95% of patients over the year were seen within four hours

- We have continued to **work closely with our partners** at Barnsley Metropolitan Borough Council and the third sector. We were proud to be named as one of only eight areas across the country to develop **integrated personal commissioning** – putting the commissioning decisions of their own health care into the hands of patients

- We have worked with the **Yorkshire Ambulance Service** (YAS) to assure ourselves of their prioritisation of patient safety and their ability to remediate their persistent non achievement of the national target of 75% Category A calls being responded to within eight minutes (see section 3.6). As identified in section 6.7 our Quality and Patient Safety Committee has undertaken work culminating in a meeting between our Medical Director, Chief Nurse and Chief Officer and the Medical Director and Director of Standards and Compliance from YAS in March 2015. Whilst noting that risk can never be totally minimised and incidents in relation to delay do occur, we were assured that there is good evidence to demonstrate that there is real time safety surveillance (through the new role of the Clinical Duty Officer in each 999 Control Centre); checking of all responses not meeting the eight-minute response target for any safety issues; learning from any incidents and new systems to improve response times. It was this latter aspect that The Governing Body then focused on when they subsequently met with YAS's Chair and full Executive Team. We highlighted that despite the evidence of patient safety work it was very hard not to be concerned and to have confidence that safety was being prioritised given the persistent poor performance. The Governing Body members shared their long-held concerns to emphasise our commitment to getting the best service possible for our patients. YAS were able to share the work they were doing to improve response times and the early improvement now resulting from this. The focus on this will remain in the forthcoming year to improve ambulance service outcomes for the people of Barnsley on a sustainable basis.

- Across our practice membership we have done considerable work to **develop the role of primary care** across the borough. We have received delegated responsibility from NHS England to take over the commissioning responsibilities of primary medical services from 1 April 2015. We have also worked hard on coming together to share the best ways of working and to have more control over what we know can work best locally.

We have been getting **feedback and working with local people** on a range of topics this year to help inform our services. These include:

- A review of tuberculosis services in Barnsley
- Proposals of ways to improve access to dermatology services by offering teledermatology clinics in GP practices
- Proposals to improve access to care for common eye conditions by offering more services in opticians
- Development of our end of life care strategy and input into the development of a website offering advice for patients, families, friends and carers, centred around end of life
- Children, young people and families have let us know what services are important to them and what the priorities should be
- Access to and experience of health services if you are deaf
- A review of respiratory services
- How services should be more joined up and should work for patients and families, not just the services who provide them.

These are just some of the things we have been talking to people about over the past year. We have done this through a variety of ways from talking to individuals, groups, forums and networks. We have also worked closely with Healthwatch Barnsley, the Barnsley Patient Council, practice patient reference groups and members of our OPEN network and partner organisations who help share and provide feedback.

2.3. Our annual evaluation statement

Throughout the year we have been reviewing our effectiveness in a number of ways. Similarly to other CCGs, our Governing Body has regular meetings with the NHS England Area Team. This offers a level of scrutiny and assurance to the way we do business. We have also continued to build our capability through a programme of organisational development. Our Governing Body meetings are held in public at venues across the borough and we encourage people to take part in the discussions via social media, which has proved popular.

This report covers a period when the CCG has shown that we are confident and capable of performing at the highest level. That achievement is testimony to the skill and dedication of all our members, staff and partners; and we must begin this year's report by thanking them for their tremendous efforts.

3. Strategic report

3.1. About us and our community

Based in South Yorkshire, NHS Barnsley CCG represents 36 GP practices with over 244,000 registered patients. We have responsibility for commissioning healthcare for the population of Barnsley – planning, buying and monitoring high quality services. Because decisions are made locally, we make sure that the focus is on the health problems that affect people in our area.

The steps involved in ensuring we meet local health needs are:

- Determining the needs of local people to improve health outcomes, reduce health inequalities and prevent ill health
- Finding out what people think about the healthcare they receive
- Designing better ways to deliver healthcare
- Contracting with other organisations to provide the healthcare services that are needed
- Monitoring the healthcare provided to make sure it is of the right quality and offers good value for money.

We do this by commissioning or buying health and care services including: hospital care; rehabilitation care; urgent and emergency care; most community health services; mental health; and learning disability services.

We also do this with patients and healthcare professionals and in partnership with local communities and other local organisations such as the local authority and other NHS organisations.

Clinical commissioning groups are member organisations and representatives from the 36 Barnsley GP practices form part of the NHS Barnsley CCG Membership Council. As members, the practices nominate/elect representatives to the Membership Council and the Governing Body. The Governing Body of the CCG provides oversight and assurance as well as giving strategic direction to the CCG's activities. Its role is to provide constructive challenge and support, to ensure that the CCG can be as effective as possible in delivering our statutory function. All our Governing Body members live or work locally, so they all have a real interest in making sure that health care services for the people of Barnsley are the best that they can be. You can see details of all our practices on our website: www.barnsleyccg.nhs.uk/about-us/membership.

3.1.1. Our vision and values

We have set out our vision for Barnsley which is underpinned by our values and principles. This vision will guide and inform our work, along with the local population's health needs and experience of health care.

The vision for NHS Barnsley CCG is:

"We are a clinically led commissioning organisation that is accountable to the people of Barnsley. We are committed to ensuring high quality and sustainable health care by putting the people of Barnsley first."

Our values underpin everything we do as commissioners and an employing organisation. They are:

- Equity and fairness
- Services are designed to put people first
- They are needs led and resources are targeted according to needs
- Quality care delivered by vibrant primary and community care or in a safe and sustainable local hospital
- Excellent communication with patients.

3.1.2. Barnsley people

We use a variety of data to understand the health needs of Barnsley people. Some of it comes from national statistics, some of it comes from trends and patterns we see in how people access health services locally and some of it comes from listening to what Barnsley people tell us about their experience of services now. However, we have made a commitment to be exemplar in patient, public and carer engagement and it this work we are most keen to progress as a CCG. Having a deep understanding of what local people want from their services and working alongside them to shape and influence the often difficult decisions that need to be taken about the services we commission in the future, has continued to be our focus in 2014-15.

The CCG has a legal duty Section 242 to involve current and potential service users or their representatives in everything to do with planning, provision and delivery of NHS services.

The duty specifically applies where there are changes proposed in the manner in which services are delivered or in the range of services made available.

3.1.3. Local voices

Throughout 2014-15 we have developed our approach to listening and working with local people to ensure they are both engaged with what and how we commission healthcare services and also that they participate in the decisions about their own healthcare.

We made proposals to change the way people could access assessments and care for **minor, common eye conditions**. In the existing system people went to see their GP who would then often refer them on to a specialist team at Barnsley Hospital if deemed necessary. There were large waiting lists and it was often inconvenient for people to travel to the hospital. The proposal was to move some elements of this service to local opticians across the borough. The overall feedback was very positive and people were in support of flexible appointment times, access across the borough. They said they could also see the benefits for those patients who had conditions which did need specialist treatment, as they could now be seen sooner.

People asked us if the quality of care would still be the same and we were able to offer assurance that all the participating opticians have fully trained optometrists who are highly trained for assessing and treating these types of eye conditions. People were also keen to ensure there was equal access across the borough. Whilst we could only encourage opticians to take part, we were pleased to see around 20 opticians sign up to the scheme.

Similar to common eye conditions, we reviewed the way **skin conditions and dermatology** services were managed. Any conditions that GPs were unsure of were being referred through to the specialist team at the hospital. It was identified that a large volume of these conditions could be assessed through the use of teledermatology. This allows the GP to take a high resolution image on a special camera of the skin and send it directly to the specialist team. The team are then able to assess the skin image, together with additional information from the GP, without the need for the patient to attend an outpatient clinic at the hospital.

When we talked to people about what they thought of these proposals they were supportive and in agreement that this could bring benefits for patients, speeding up treatment for both people who didn't need further treatment as well as those who needed specialist, ongoing support.

We developed a new **Barnsley end of life care strategy** this year and asked people locally about what made their experience of services locally good, as well as asking what they would like to see improved. We understand that end of life care is a sensitive subject, and can be difficult to talk about. However, the CCG is committed to talking openly about this

issue to make sure that every resident in Barnsley receives the best possible care at the end of their life. Essential to the development of an effective strategy, alongside recent national policy guidance, is for this to be informed and shaped primarily by the views, wishes and recent experiences of local patients and their carers.

In brief, respondents to the survey highlighted that the most positive aspects of end of life care services in Barnsley in their personal experiences related to the following areas;

- The staff (kindness shown, positive and caring attitude)
- The quality of the communication and information provided
- The level and range of services available
- How responsive and supportive those local services had been in their experience.

The areas that in their own personal experiences they felt could be improved upon in relation to end of life care services in Barnsley related to the following areas;

- Improved communication and information with this being more joined up across services
- The removal of layers of bureaucracy and red tape
- Ensuring the right level of support and input is provided for each individual
- The provision of suitable pain relief and equipment and
- An improvement in some areas in the attitudes and sensitivity shown towards patients and their families.

This first phase of engagement has only provided us with a snapshot of the views and experiences of patients and carers regarding end of life care services from across Barnsley, their valuable comments and the insight they have provided will be fed back to the lead commissioners within the CCG and used to help to inform the development of the next end of life care strategy for Barnsley.

We also talked to people about **tuberculosis (TB) services** in Barnsley. Engaging with patients, carers and other key stakeholder groups forms a crucial part of the overall review to ensure that the views, feedback and experiences that they share helps to influence and inform future service development based around the needs of the local community.

Taking into consideration the very small sample size of patients who had accessed these types of services, the majority of those that we spoke with were in the main happy with the particular aspects of the service that they had received and several provided particular praise for individuals who had taken the time to ensure that they were in possession of the information and medication they required. The findings will contribute to developments in how TB is managed across Barnsley in the future.

Following a CCG public event earlier last year to discuss our commissioning priorities, Healthwatch Barnsley approached us to say that members of **Barnsley Deaf Forum,** who had attended the event, would like to tell us more about their **access to and experience of health services**. Throughout the year we have been working with partners and local people to work through a series of feedback and action events. People have had the opportunity to talk about mental health, hospital, ambulance and GP services. Each of the agencies now has an action plan. We will continue this work next year.

Together with our member practices, we did some significant work to **support local patient reference groups** (PRGs) in GP practices. We recognise that these groups are key to influencing services and they have excellent insight into what works and what could be improved. Our aim was to ensure that everybody had access to a patient reference group whether that be a virtual one or one that meets in person. This work will develop into next year as we work with PRGs and the patient council to link in with their local communities more.

3.1.4. Local population

The 2013 mid-year population estimates from the Office for National Statistics showed that there are approximately 235,800 residents[1] across the borough. 21% of the population are aged under 18 years, 61% aged 18 to 64 years and 18% aged 65 years and over. Population projections estimate that the population will be 242,000 by 2017 which is an increase of 2.6% from the mid 2013 estimate. The most significant changes are increases in the under 10s population and also the over 65s as a result of people living for longer. We have to look at the number of residents in the borough as well as the number of people who are registered with a GP in the borough to fully plan for local services.

How deprived an area is classed also gives us an indication of some of the health needs of local people. Barnsley is ranked as the 47th most deprived borough of 326 local authority districts, with 32% of the population living in the 20% most deprived areas in the country. We also have 24% of children in Barnsley currently living in poverty.

3.2. Our strategy

The Strategic Commissioning Plan set out our top priorities, as a CCG and with our partners for 2014-15 as:

- Review and commission intermediate care services

[1] This differs from the total list size of 244,000 set out in 3.1 due to patients outside the Barnsley boundary being registered with Barnsley practices.

- Redesign and re-specify care pathways for people with long term conditions e.g. diabetes
- Develop high-quality primary care services which are accessible across the borough
- Reconfigure social care assessment and care management arrangements
- Develop universal access to information and support for patients, service users, staff and carers to encourage and support self-management and care
- Early intervention in mental well-being
- Implementation of the Young People's Health and Wellbeing Strategy including development of services to promote emotional wellbeing in children and young people
- Establishing a care coordination centre.

There have been a number of developments in 2014-15 which will impact upon the delivery of our vision and therefore the Strategic Commissioning Plan has been refreshed to take account of these. Two of the significant areas of development are the delegated commissioning of primary medical services, giving us more influence over the whole healthcare economy and the publication of the **NHS Five Year Forward View** in autumn 2014 setting out how the NHS will develop and change over the next five years.

3.3. Our business model and how we work with partners

We are a commissioning organisation responsible for ensuring the provision of health services for the people of Barnsley with a view to improving health and healthcare services and reducing health inequalities. We do this by commissioning high-quality health services from a range of providers including Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership NHS Foundation Trust and Yorkshire Ambulance Service along with a range of other providers to ensure services are available to meet the needs of our population.

As a tangible demonstration of our commitment the CCG invested £9.2m of non-recurrent resource in our main two providers to support transformational development and improvement of systems resilience. Further funds were committed non-recurrently to other bodies including Yorkshire Ambulance Service. A breakdown of non-recurrent investment in Barnsley Hospital NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust is detailed in the following table:

	Non-recurrent investments		
	Barnsley Hospital NHS Foundation Trust	**South West Yorkshire Partnership NHS Foundation Trust**	**Total**
	£'000s	**£'000s**	**£'000s**
Support for seasonal activity pressures (approved by System Resilience Group (SRG))	1,773	830	2,603
Seven-day services	1,895		1,895
Investment in transformation/development schemes identified by each trust	3,678	1,068	4,746
Total investments	**7,346**	**1,898**	**9,244**

* For more information on SRG see page 26

In order to deliver our overall vision and objectives we recognise that we cannot do everything on our own and therefore we work with our partners and providers of health and care services in Barnsley and across South Yorkshire and Bassetlaw.

Locally, we are active members of the **Health and Wellbeing Board** in Barnsley and play a key role, working with our partners in delivering the Health and Wellbeing Vision for Barnsley as set out in the Health and Wellbeing Strategy 2014-19.

The Health and Wellbeing vision for Barnsley is:

> "Barnsley residents, throughout the borough, lead healthy, safe and fulfilling lives and are able to identify, access, direct and manage their individual health and wellbeing needs, support their families and communities and live healthy and independent lifestyles."

To deliver this vision and move to a model of health and care which will apply into the future will require some significant changes to the way that health and care services are currently commissioned and delivered. Our focus, with our partners will therefore be on providing care and support to the people of Barnsley with services that:

- Co-ordinate around the individual – targeted to their specific needs
- Maximise independence – by providing more support at home and in the community
- Better co-ordinate information, advice and sign-posting to alternative services to promote self-help and self-care

- Develop more effective prevention, re-ablement and targeted short-term interventions to keep people out of the formal system for as long as possible
- Support people to manage their long term conditions and those with the greatest needs.

In 2014-15 we developed and agreed our plan for the use of the '**Better Care Fund'** pooled budget in 2015-16. This plan is fully aligned to the wider Health and Wellbeing Strategy but is specifically aimed at:

- Reducing emergency admissions to hospital
- Reducing delayed transfers of care
- Improving the effectiveness of re-ablement and rehabilitation services
- Reducing inappropriate admissions of older people (65+) into residential and nursing care
- Improving patient and service user experience and the use of patient experience information to improve services
- Increasing the proportion of people aged 65 and over who suffer from a long term condition who feel supported to manage their condition.

Together with our health and wellbeing partners we expect this to deliver:

- Easier access to information and advice to both help people make the choices which matter to them about their care and support and for staff to navigate services
- Reduced reliance on traditional, statutory services, sign-posting people to alternative services
- Fewer admissions to care homes and for shorter duration towards the end of life
- Improved 'welfare' support, particularly those who are isolated, lonely and or have poor mental wellbeing

- Care and support needs met locally wherever possible with an enhanced choice of support options
- An increased level of self-care and people managing their own care and support needs
- Fewer admissions to hospital and less time spent in hospital for patients who need to be admitted
- More cost-effective use of resources
- More appropriate use of clinicians' / professionals' time so that they can concentrate on issues for which they are trained and skilled
- An opening up of the provider base and therefore an increase in the range of services offered, leading to a more holistic package of care.

In the spirit of partnership and in advance of the full functioning of the Better Care Fund, the CCG has supported partnership working with Barnsley Metropolitan Borough Council and provided a significant contribution of funds to this joint working agenda including services for both adults and children. A breakdown of CCG funds contributed to the Local Authority in 2014-15 is detailed below:

	£'000s
Local Authority Commissioned Services	
Reablement (helping people regain the ability to look after themselves following illness or injury)	2,363
Carers Funding	813
Barnsley Participation Process	141
Support for BMBC initiatives	359
Mental Health Services	303
Support for seasonal activity pressures	285
Jointly Commissioned Services	
Substance Misuse	2,499
Children and Young Peoples Trust – NHS contracts	3,749
Children and Young Peoples Trust – other commissioned Services	567
Joint Commissioning Arrangements	288
Total Contribution	**11,367**

As a health and care community, we are already recognised as a **'Pioneer'** for Integrated Services and in 2015-16 will continue working together on the **Stronger Barnsley Together** Programme to deliver ongoing improvements and further integrate services where this will lead to improved services for patients and service users and their carers.

While working locally with partners and providers is helping us to improve local services, we also recognise that there are particular circumstances where it clearly makes sense, both financially and clinically, to work with neighbouring CCGs and NHS England to develop areas of work and commission services together. Our main mechanism for doing this is through the **Working Together Programme**.

Towards the end of 2013, as CCGs approached the end of their first year of establishment, we agreed a significant commissioner led programme of work to review and re-design a number of services across a wider geography served by eight CCGs. This was our commissioner Working Together Programme which worked with our hospital's own Working Together Programme, covering the same geographical area. The two programmes are closely aligned and represent the South Yorkshire, North Derbyshire and Wakefield Health systems working closely to improve services and increase the effectiveness of every pound we spend on Healthcare.

The Working Together Programme has stated:

"Our work across our four initial agreed areas, children's services, cardiovascular, smaller surgical and medical specialties and urgent and emergency care has been in partnership with our hospitals and our clinicians and made good progress. We are in a unique position to build on our collaboration so far to make the changes required of the NHS that are set out in the Five Year Forward View with the support of our clinicians and our patients. This programme is a major commitment for this group of CCGs but one that is necessary to realise the significant changes that will deliver both improved outcomes and respond to the national requirement to find £30 billion of efficiencies in the way we deliver healthcare."

The scope of the Working Together collaboration extends and includes eight CCGs and NHS England, covering a population of approximately 2.3 million people.

The establishment of the Working Together Programme took place at a time when the NHS had recently undergone a period of fundamental change and CCGs and NHS England were relatively new organisations. It was also at a time when there was an increased emphasis on the need to improve quality and outcomes of care and when we are seeing rising demand for services, due to an ageing population, an increasing burden of chronic diseases and increasing patient expectations and a requirement to fundamentally review how we commission and deliver services to improve quality and deliver efficiency.

In this first phase of commissioners working together, the focus has been on a small number of services areas. In these areas there was agreement from all commissioners that these

would benefit from collective action and by working together we could make a demonstrable difference to improve the quality and efficiency of these services.

The priorities in phase one have been children's services, cardiovascular, smaller surgical and medical specialties and urgent and emergency care this work has been progressed in partnership with our hospitals, clinicians and managers and key stakeholders.

Good progress has been made and as a result of our work in phase one we have been able to make changes to services which will have a direct impact on the quality and experience of patient care. In 2015-16 a new model of service for patients who have had a particular type of heart attack will be implemented. In addition, we have been able to develop a detailed understanding of the challenges facing some of our specialist services, for example hyper acute stroke and children's surgery to inform our case for change in these areas to improve the quality of care.

We have established a programme office and approach and have been able to test a range of methodologies to help guide our working. Through clinical workshops and stakeholder events we have engaged with key stakeholders in these service areas and wider.

In October 2014 our programme was reviewed by the Department of Health Gateway Team. The review provided some significant insights which have guided a number of changes to the programme and approach. In addition there has been significant learning from our initial work, which we constantly reviewing and applying.

The publication of the Five Year Forward View has reinforced the confidence we stated in 2013-14. We are on track and one of the approaches will enable us to deliver the significant change outlined in the Forward View, particularly across a wider geographical footprint and where pathways of care cross both provider and commissioner boundaries. In addition the Dalton Review has offered new opportunities for providers and the approaches in the two programmes align well to those advocated in these two key documents.

Phase two of the Working Together Programme will continue to deliver on the commitments started in phase one, including improving the provision of children's services and stroke services. There is also a commitment to increase the ambition of the programme and this will be underpinned with a strategic review across the *Working Together* footprint. In addition we will be working with the King's Fund to develop our thinking and ambitions for new models of care and the opportunities of taking a collaborative approach to commissioning.

Looking forward, and to take account of the NHS Five Year Forward View, we will work with our partners to strengthen the Working Together Programme in order to maximise the potential of working together and deliver the vision of the programme which is to:

> "Commission together to efficiently deliver improved patient outcomes for all of our local populations."

3.4. Our achievements this year

The CCG has made significant progress over the past year investing in and commissioning those services which will reduce health inequalities; improve access; support people to be more in control of their conditions and bring care closer to home.

We have invested in services delivered by the local NHS, local authority and with the local voluntary and community sector, working together to make the most of the skills and expertise in our area.

We made a commitment, along with partner organisations, to become a **dementia-friendly** town and in June last year we encouraged people to become a Dementia Friend. People with dementia can often feel alone and isolated and, by becoming a Dementia Friend, people can help them to live well for longer. We also made an ambitious commitment to ensure that people with dementia received a timely diagnosis. This figure grew by 5% over the year allowing more people and their families to access much needed support and services.

We were delighted to be announced **winner of the national Cervical Screening Awards** run by Jo's Cervical Cancer Trust alongside our colleagues at Barnsley Council. The winning Fear or Smear campaign was developed to increase the uptake of cervical screening in women aged 25-29 years across Barnsley following statistics that show nearly 29% of this age group in Barnsley fail to attend screening when invited.

We **developed two websites** this year, bringing vital information and advice to the fingertips of local people. The first is dedicated to cancer (www.cancer.barnsleyccg.nhs.uk) and brings together all the information, from prevention to treatment and survivorship, together. It uses the national best practice advice and guidance and has local detail in there too, such as support groups or wellbeing services for example. The second site, which will go live in summer 2015, focuses on end of life care and is aimed at patients, their families and carers, as well as healthcare staff working with them. Both sites will be a tremendous resource for people locally and we will continue to add to them as we move into next year.

We worked closely with our partners and local people this year to develop the **end of life care strategy** for Barnsley, which will be formally launched in 2015-16. Outlining our commitment to high-quality care, the strategy also outlines those things which matter most to people.

We have made significant progress this year in bringing services together to improve both the experience and the outcome for patients. The new **RightCare Barnsley** nurse-led team

has provided a single point of access for GPs co-ordinating care for patients who may have otherwise been at risk of being admitted to hospital within 24 hours. The team works with both community services and the hospital to ensure that patient gets the right care at the right time and in the right place.

In spring 2015 the CCG was **announced as one of only eight pilot sites nationally** to implement a new way of commissioning health, which puts the decisions directly in the hands of the patients. In Barnsley, people who use services and their carers, along with health and social care partners will be working together to develop the model to support people with complex diabetes. This new approach will help people who have lots of contact with services, such as hospitals for example, or have difficulty managing their diabetes because of other long term health conditions. People will be supported to take more control of their own health and wellbeing needs, using support plans tailored to them and funding to reflect what works for the individual in managing their own health conditions.

Integrated personal budgets is just one of the many things the CCG has done this year to shift the balance away from 'what is the matter with you' to '**what matters to you'**. We have been **recognised nationally** for the work we are doing to focus on the relationships health and care workers have with individuals in supporting and encouraging them to be more involved in decisions about and management of their own care and conditions. We have been working in the Hoyland community to test a range of behaviour change tools and techniques as well as working with local people to understand better how they want to manage their own conditions. This **community-wide approach** will continue into 2015-16 and we are excited to see the results and share the learning. The work we have done in this area has attracted national interest and our approach has been picked up by the national NHS Health Checks team who have invited us to share and showcase the work of Barnsley, nationally.

Access to services is always on people's lists when we go out and talk to them and this year we **implemented two large-scale services** which have seen us improve access and make the most of the skills and expertise across the NHS:

- We have developed a service in GP practices to assess and manage **minor skin conditions**, using technology to help assessments. This means that people can be seen and often treated by their GP, close to home, without the need to visit the hospital. This will not only improve the access for those people who can be seen by their GP but it also means that the specialist team at the hospital can see and treat those people who need it much more quickly
- We also built on the success of the PharmacyFirst service by working with opticians across the borough to offer a service for people with common and **minor eye conditions**. This means people can be seen by their local optician at a time which is convenient to them and know they are being seen by a trained expert.

The CCG made a significant decision this year to apply to take on **delegated commissioning arrangements for primary medical services** from NHS England, allowing the CCG a much greater opportunity to improve primary care services for local patients. NHS England fully supported our application and this change will come into effect in 2015-16 and forms the cornerstone of or plans ensure Barnsley patients have access to high quality and sustainable services in primary care.

Our primary care development team have been able to offer experience and support to GP practices, working alongside them to really understand what their patients are saying matters to them. This insight has been essential when looking ahead to see what vibrant, local health care service should look like in Barnsley now and in the future.

As part of this work, we have developed an **innovative agreement plan, co-produced with GP practice teams**, with a key aim of improving the quality of care patients receive from their GP practices through expertly-trained staff and better resources.

As a result of the Practice Delivery Agreement (PDA), patients will have access to a better range of services, for example the delivery of warfarin clinics within practices, benign prostate treatment and improved treatment of diabetes and heart disease.

Practices will also adopt the '**Year of Care'** model, which aims to provide personalised care planning for people with long term conditions, by working in partnership with patients and care professionals.

'Anticipatory Care' will see GPs visiting the elderly and housebound in their homes or at their preferred place of care to mutually agree a personal care plan and offer medication reviews and discussion of end of life care.

A key aspect of the agreement is patient and public engagement, and the PDA actively encourages practice patient reference groups which are vital in seeking the opinions of and addressing the needs of the local population.

The PDA will also target the demographic health challenges faced by the people of Barnsley and will actively address and reduce health inequalities in the town. Another aspect will see GP practices being encouraged to operate in an environment of continuous learning, training and development to ensure a continuing improvement in standards. A GP Fellowship scheme is also being developed aimed at attracting more GPs to the area.

Alongside the practice delivery agreement, a quality framework has been developed to enable all practices to provide quality services and an equality of service provision to the Barnsley patient population. The development of the **Barnsley Quality Framework** (BQF) was carried out in conjunction with member practices and the Practice Managers group.

This created a platform of engagement which increased membership participation and shared decision making.

During this year the BQF success was reflected in the sign up of 34 out of 36 practices, it was not a requirement in that practices sign up to all the services within the BQF. In 2015-16 the BQF will form part of the Practice Delivery Agreement, meaning that all those practices signed up to the PDA will provide all the services that form the BQF to their patient population.

The aim of framework is to enable the CCG to work with its member practices to explore the potential range of benefits available locally from delivering primary care at scale. It will focus on three priority strands of: Health Promotion and Prevention; Clinical Management; and Patient and Public Engagement.

The CCG has also worked intensively this year with GPs to support their development and formation of a local federation and saw a tremendous end to 2014-15 as **Barnsley was awarded £2.26million** funding as part of the Prime Minister's challenge fund to **extend access to primary care services**.

The bid pulled in all the elements of our vision for improving services for Barnsley patients. Developed by the CCG and the new federation, the plans put the doctor's surgery at the heart of patient care and aim to bring together many more services, making it easier for people with complex conditions who often find it a challenge to navigate their way through the system.

There will also be significant investment in both the time and the way patients can access services. For the many patients who use social media and the internet to manage the rest of their life, the same options will be available during these extended hours, with online booking, email consultations, video conferencing (face time appointments), telephone assessments and follow ups.

This year saw the formation of a **System Resilience Group** (SRG) made up of local health and social care services and led by the CCG. The role of the group is to work collaboratively, planning services for patients, particularly over the winter period when they are in high demand. Made up of leaders from each organisation, the group has been able to look at those areas in Barnsley which require additional investment and a more integrated approach to ensure that patients are seen in the right place at the right time.

The SRG in Barnsley developed and oversaw the delivery of operational resilience and capacity plans which resulted in investment of over £4m in schemes designed to improve capacity and resilience across the system, particularly over the winter period. In Barnsley the schemes ensured additional capacity in the acute and community sector; additional social work capacity (including seven-day working); increased capacity of the Independent

Living at Home service, enhanced use of assistive technology; the introduction of Urgent Care Practitioners by Yorkshire Ambulance service and pilot projects for supportive volunteering and social prescribing. There was also investment in mental health services in recognition that mental and physical health are equally important.

The additional investment along with the hard work and partnership working throughout the year ensured that performance was maintained and particularly that the Accident and Emergency four-hour standard was achieved in 2014-15 with over 95% of patients being seen and treated within four hours.

3.5. Our performance

Our Strategic Commissioning Plan 2014-19 set out our ambitions for improving outcomes for Barnsley residents over the five years of the plan.

There were five outcome measures against which we were required to set out our level of ambition. These measures along with an assessment of our performance over the first year are included in the table below.

Outcome Measure	**NHS Outcome Domain**	**Latest Performance**
Securing additional years of life for the people of England with treatable mental and physical health conditions.	Preventing people from dying prematurely	The potential years of life lost has been reducing year on year for the last four years and if this trend has continued when 2014 information becomes available, we will have achieved the planned target.
Improving the health related quality of life of the local people in Barnsley with one or more long-term condition, including mental health conditions.	Enhancing the quality of life for people with long-term conditions, including those with mental illnesses	Performance has improved from the 2012-13 baseline. However the latest score remains slightly below our target.

Outcome Measure	NHS Outcome Domain	Latest Performance
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital – reducing emergency admissions.	Helping people to recover from episodes of ill-health or following an injury (NHS Outcomes Framework)	This is assessed using a composite measure. It is not possible to assess progress accurately against this as now data is available for 2014-15. However, performance against 3 of the 4 individual members is showing an increased level of emergency admissions at quarter 2 of 2014-15.The CCG strategy towards out of hospital care and the schemes in the better care fund are designed to reduce emergency admissions and this should have a positive impact in 2015-16
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care.	Ensuring that people have a positive experience care (NHS Outcomes Framework)	There has been no more up to date information published since our plan was set and therefore it is not possible to assess achievement. However we continue to work with providers to improve patient experience.
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community.	Ensuring that people have a positive experience care (NHS Outcomes Framework)	The targets for this measure were set based upon 2012-13 performance which was 5.3. Latest performance shows that this had declined in 2013-14.Work is ongoing as part of the primary care strategy and with providers to improve patient experience however there will need to be significant improvements to reverse the drop in performance between 2012-13 and 2013-14.

We also set ourselves ambitious targets for improving dementia diagnosis which has seen the diagnosis rate improve from 47% in 2012-13 to 61% in 2013-14 and to 64.09% in 2014-15. Dementia diagnosis rates therefore remain lower than the nationally set target of 67%. We will continue to work with GP practices in 2015-16 to improve diagnosis rates.

The numbers of people who contract healthcare associated infections such as MRSA and C.difficile have reduced during 2014-15 as a result of our ongoing focus, along with that of our providers, on quality and patient safety.

We have also improved access to psychological therapy for those people with depression and/or anxiety disorders during 2014-15, with 15% of people who suffer now accessing services.

3.6. Key performance indicators

All patients should receive high-quality care without any unnecessary delay. Patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, will be able to be seen and receive treatment more quickly. Performance is monitored across all waiting time pledges. During 2014-15, performance against the majority of the constitution measures has been above the target/standard and the year-end performance information confirms this.

The table below sets out the NHS Constitution measures and shows whether performance has been in line with the target/standard. The areas where performance has been below target are waiting times for diagnostic tests and ambulance response times for the most urgent calls.

The CCG provided additional investment to improve capacity in diagnostics at Barnsley Hospital during 2014-15 to drive improvements which resulted in improved performance but not to the required level. However, further improvement is anticipated during 2015-16. Ambulance response times for the most urgent calls were below the target for most of 2014-15 and we have worked with Yorkshire Ambulance Service to improve performance during the year however, this has not resulted in sufficient levels of improvement. Therefore, an action plan has been developed to drive improvement and ensure appropriate oversight of performance into 2015-16. Further details about our work with the Yorkshire Ambulance Service to improve performance can be found in section 6.7.

Referral To Treatment waiting times for non-urgent consultant-led treatment	
Admitted patients to start treatment within a maximum of 18 weeks from referral – 90%	Achieved
Non-admitted patients to start treatment within a maximum of 18 weeks from referral – 95%	Achieved
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – 92%	Achieved
Diagnostic test waiting times	
Patients waiting for a diagnostic test should have been waiting less than six weeks from referral – 99%	Not achieved
A&E waits	
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department – 95%	Achieved
Cancer waits – 2 week wait	
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – 93%	Achieved
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) – 93%	Achieved
Cancer waits – 31 days	
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – 96%	Achieved
Maximum 31-day wait for subsequent treatment where that treatment is surgery – 94%	Achieved
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – 98%	Achieved
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – 94%	Achieved

Cancer waits – 62 days	
Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer – 85%	Achieved
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – 90%	Achieved
Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers) – no operational standard set	Achieved
Category A ambulance calls	
Category A calls resulting in an emergency response arriving within eight minutes – 75% (standard to be met for both Red 1 and Red 2 calls separately)	Not Achieved
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – 95%	Achieved

3.7. Financial commentary

Barnsley CCG came into existence on the 1st April 2013 and the accounts appended to this Annual Report represent the financial performance of the CCG in its second year of operation.

Throughout 2014-15, the CCG has constantly improved its assurance processes to ensure that these are robust and fit for purpose. Key to this successful development has been:

- Revision of detailed financial management policies to reflect the responsibilities of Boards, Committees and individuals in respect of governance
- Development and strengthening of financial, contractual and performance reporting to the Governing Body and Finance and Performance Committee, to ensure messages are clear and mitigating actions identified
- Utilisation of prioritisation and reprioritisation meetings to ensure mitigating actions are identified and approved. This has included an in-depth mid-year financial review to ensure that the CCG was well placed to meet all financial obligations

- Development and on-going review of arrangements with Yorkshire and the Humber Commissioning Support Unit to ensure that services provided to the organisation under the service level agreement are fit for purpose and robust

- Working ever more closely with partner organisations to resolve issues regarding commissioning responsibilities and to ensure that clear governance arrangements are in place to manage these relationships.

These developments have led to significant assurance being recorded by Internal Audit with regard to the CCGs systems of financial control.

The financial outturn for Barnsley CCG in 2014-15, as shown in the Annual Accounts is expenditure of £358,121k against a Revenue Resource Limit of £368,602k. This means that the CCG has delivered a surplus of £10,481k in line with the required surplus agreed with NHS England and has achieved its primary financial duty of not spending more than it receives. Furthermore, in terms of the £6,785k allocation in respect of Running Costs, the CCG has recorded expenditure of £5,765k, an underspend of £1,020k which has been utilised to support delivery of health services to the population rather than on administration costs.

The CCG has also ensured it has made best use of the Barnsley £ in all of its investments. This has been achieved through Governing Body scrutiny, and oversight by the Finance and Performance Committee, and the Executive Management Team. In addition, Programme Boards have been in operation to manage investment portfolios and have done so while bearing in mind value for money considerations.

The underlying financial position of the CCG remains strong and together with achievement of all statutory duties and significant assurance provided by Internal Audit, 2014-15 has been a year of consolidation and development for the CCG. Further developments are expected in 2015-16, and these together with this strong foundation fit the CCG well to deal with upcoming challenges.

3.7.1. Key financial achievements in 2014-15

The CCG achieved all of its statutory financial duties in 2014-15. The table below summarises that performance.

Duty	**Target**	**Actual Performance**	**Achievement**
Expenditure not to exceed income	£368,602k	£358,121k	Achieved
Capital resource use does not exceed the amount specified in Directions	£0k	£0k	Achieved
Revenue resource use does not exceed the amount specified in NHS Directions	£368,602k	£358,121k	Achieved
Capital resource use on specified matter(s) does not exceed the amount specified in NHS Directions	£0k	£0k	Achieved
Revenue resource use on specified matter(s) does not exceed the amount specified in NHS Directions – **programme**	£361,817k	£352,356k	Achieved
Revenue administration resource use does not exceed the amount specified in Directions – **running costs**	£6,785k	£5,765k	Achieved

In accordance with the Better Payment Practice Code the NHS aims to pay at least 95% of invoices within 30 days of receipt, or within agreed contract terms. Our compliance is set out below:

Measure of compliance	**2014-15**	**2014-15**		**2013-14**	**2013-14**
	number	**£'000s**		**number**	**£'000s**
Non-NHS Payables					
Total Non-NHS Trade invoices paid in the year	8,167	42,427		6,389	37,974
Total Non-NHS Trade Invoices paid within target	7,985	42,107		6,108	35,919
Percentage of Non-NHS Trade invoices paid within target	**97.77%**	**99.25%**		**95.60%**	**94.59%**
NHS Payables					
Total NHS Trade Invoices Paid in the year	2,413	267,132		1,663	254,577
Total NHS Trade Invoices Paid within target	2,381	266,910		1,587	254,288
Percentage of NHS Trade Invoices paid within target	**98.67%**	**99.92%**		**95.43%**	**99.89%**

The CCG has ensured, along with Yorkshire and the Humber Commissioning Support Unit that **performance in regard of Better Payment Practice Code has improved significantly** from 2013-14 and will continue to ensure all efforts are made to maintain and improve on this performance.

3.7.2. Where do we spend our money?

The resources allocated to the CCG have been effectively utilised throughout the financial year in order to ensure that best use is made of the Barnsley £ to improve health outcomes for Barnsley residents in line with its stated commissioning intentions. The table below details the key areas of expenditure in 2014-15 compared with 2013-14.

	2014-15		**2013-14**		**Comparison**	
	Expenditure £'000s	**Percentage of Expenditure employed**	**Expenditure £'000s**	**Percentage of Expenditure employed**	**Increase in expenditure £'000s**	**Movement in share**
Acute Services	195,178	54.5%	186,231	54.4%	8,947	0.1%
Mental Health Services	33,640	9.4%	35,034	10.2%	-1,394	-0.8%
Community Services	36,062	10.1%	35,107	10.3%	955	-0.2%

	2014-15		2013-14		Comparison	
	Expenditure £'000s	**Percentage of Expenditure employed**	**Expenditure £'000s**	**Percentage of Expenditure employed**	**Increase in expenditure £'000s**	**Movement in share**
Continuing Healthcare	16,374	4.6%	15,526	4.5%	848	0.1%
Primary Care	54,461	15.2%	49,058	14.3%	5,403	0.9%
Other Programme Costs	16,641	4.6%	15,666	4.6%	975	0.0%
Running Costs	5,765	1.6%	5,709	1.7%	56	-0.1%
Total	**358,121**	**100.0%**	**342,331**	**100.0%**	**15,790**	

The CCG has made significant investments throughout 2014-15 in line with the stated aim of care out of hospital, including investing in primary care capacity to bring care closer to home.

3.7.3. Going concern

The accounts appended to this annual report have been prepared on the going concern basis.

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

3.7.4. Financial challenges and opportunities in 2015-16

The CCG is committed to significant investment in the development of healthcare in 2015-16 and beyond, particularly the development of out of hospital services that meet the needs of the population of Barnsley while seeking best value for the Barnsley £.

The challenge for 2015-16 and beyond will be to build upon the successes and achievements of the first two years of operation in a time of increasing financial pressures. The principal challenges facing Barnsley CCG over the coming years are:

- Restricted resource allocation growth due to the CCG being above its 'fair share' of resource allocation

- Managing financial pressures associated with an ageing population with more complex needs, particularly given the significant proportion of the population living with life-limiting long-term conditions
- Ensuring that there is a sustainable provider economy to serve the needs of the population within resources identified, particularly given that Barnsley Hospital NHS Foundation Trust, the majority provider of acute services to the CCG, is in the second year of a financial recovery plan
- A significant investment is also required in mental health services to deliver mental health transformational change
- Establishing and embedding appropriate arrangements over the health resource to be pooled from 1st April 2015 under the Better Care Fund with Barnsley Metropolitan Borough Council for joint arrangements across health and social care
- Establishing and embedding appropriate arrangements for delegated responsibility for primary medical services under delegated commissioning
- Maintaining and strengthening financial assurance and governance arrangements.

The opportunities for the CCG are as follows:

- By taking delegated responsibility for primary medical services expenditure and strategy along with joint working arrangements with the local authority under the Better Care Fund, the CCG will be enabled to influence investment across the whole health and social care system to improve health outcomes for the population of Barnsley
- Investment funds identified for out of hospital services should provide the basis for improved efficiency and health outcomes
- Ever closer working with providers and other commissioners will ensure that the best health and social care is provided to the population of Barnsley for the best value.

The underlying financial position, while challenging, provides the CCG with a strong basis to meet challenges and maximise opportunities in the coming years. Further development of governance structures and building on key relationships with partner organisations will be key to achieving the best of outcomes.

3.8. The risks we face

The CCG has put in place risk-management systems which enable us to monitor and test how health services are provided, including the performance of our commissioned services against government targets and best practice standards such as treatment times and control of infection in hospitals.

Effective incident reporting, complaints and public involvement all contribute to our risk management, and add to our knowledge of what is happening with our services and how the public receive and perceive NHS services.

Internal systems of control and communication ensure that serious issues are raised in a timely and relevant way within the CCG, so that the Governing Body can make sure actions are taken to address the risks. The Governance Statement (section 6) describes these arrangements in more detail and explains how the CCG has managed the biggest risks it has faced this year to the delivery of our objectives.

Risk management forms part of our integrated governance arrangements and evidence shows that well managed organisations have better outcomes, including:

- safe and clinically effective services for patients
- maintenance of core services in times of emergency
- better value in our use of resources
- Better health outcomes for our population.

In other words, good governance can save lives.

3.8.1. Patient safety and safeguarding

Barnsley CCG places quality and patient safety high in its priorities and aims to drive improvements across both in the services it commissions. Whilst there is much to celebrate in performance improvements over the past year, we remain focused on the challenges ahead – delivering high quality care across the pathways, across organisations and with patients in a way that transforms services. Our aim is to achieve the best outcomes for our patients and value for money with the Barnsley £.

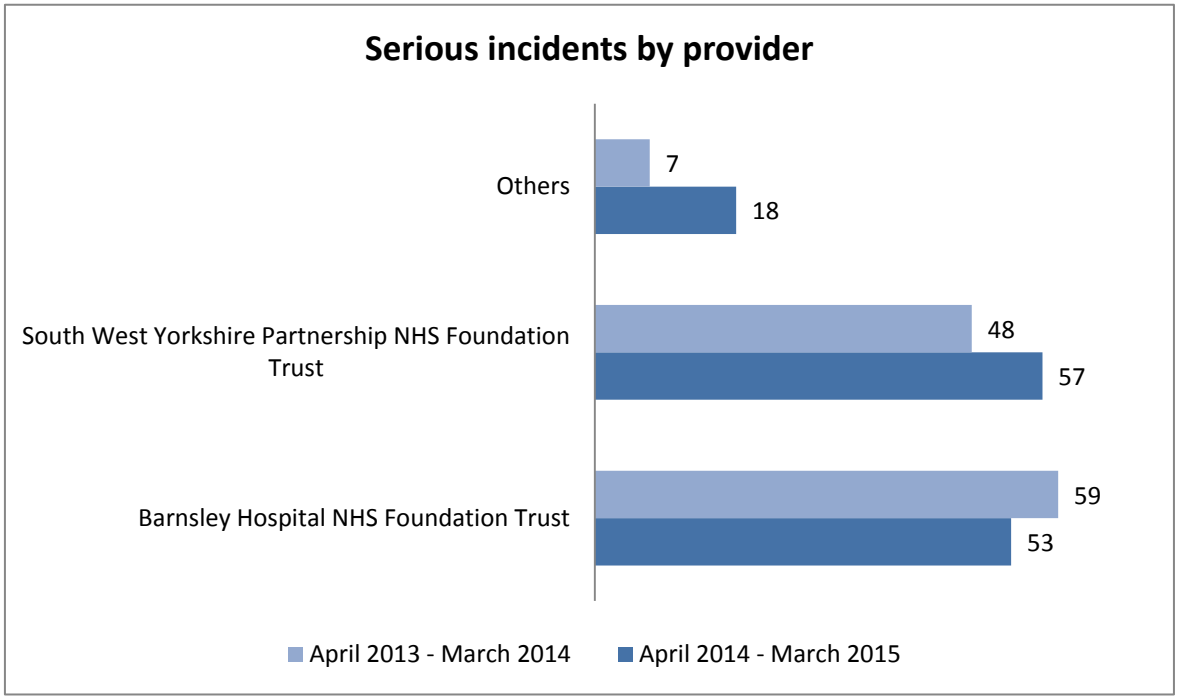
3.8.1.1. How we assure patient safety

Serious incident review meetings are held weekly and are chaired by the Chief Nurse, supported by the Medical Director, Head of Patient Safety and the Practice Manager Member from the Governing Body. A serious incident can be identified as an incident where

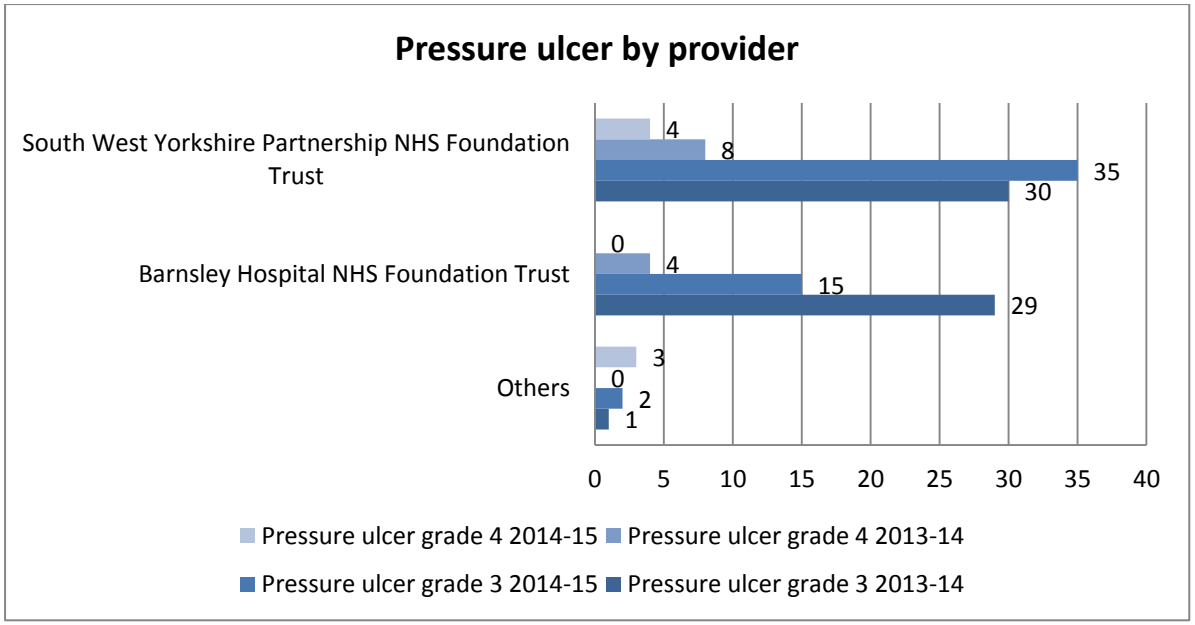
one or more patients, staff members, visitors or members of the public experience serious or permanent harm, alleged abuse or a service provision is threatened. Completed provider incident investigation reports are reviewed to ensure the robustness of the investigation and recommendations are made to the relevant provider.

We plan to improve the process of monitoring action plans, providing assurance that organisations embed the service improvement approach and continue to learn from incidents. We are also looking to further develop trend analysis to identify gaps using national statistics and benchmarking. The Quality Team prepares monthly reports for the Quality & Patient Safety Committee to ensure they are fully informed and assist their assurance of quality in services provided across Barnsley. The following graph and table indicates the number of serious incidents by providers during 2013-14 and 2014-15.

Between April 2013 and March 2014 there were 114 serious incidents in total. This number rose to 128 between April 2014 and March 2015.



In the last year, the reporting of Grade 3 and 4 pressure ulcers has improved and further work is being carried out to ensure that this improvement is consistent across providers. This can be seen in the following table and graph.



Pressure ulcer totals	Pressure ulcer grade 3	Pressure ulcer grade 4
April 2013 – March 2014	60	12
April 2014 – March 2015	52	7

Work was undertaken by providers to improve risk assessments and management to prevent pressure damage occurring. A policy for the reporting of Serious Incidents in care homes was developed and supported by training for care home managers. It is intended to build upon and improve intelligence sharing between partner health and social care organisations, external regulators and advisors. Information sources such as social media sites and patient opinion sites from the provider's websites are also considered.

3.8.1.2. Quality assurance visits

Both announced and unannounced quality assurance visits took place at the Barnsley Hospitals NHS Foundation Trust site in 2014-15, including the Stroke Unit, Ward 19/20, A&E, Medical Imaging and the Acute Medical Unit.

In partnership with the local authority, we hold constructive and informative visits with a clinical focus as well as a patient representative to ensure that we keep the patient journey and needs at the centre of our quality framework. Reports are written and recommendations are made which the CCG monitors through the contract process.

3.8.1.3. Contract monitoring

Monthly Quality and Performance meetings are held to provide a regular forum for an in-depth interrogation of quality and patient safety information against our contractual agreements. Contract Management Board meetings for both our providers are also held.

3.8.1.4. Commissioning for quality and innovation (CQUIN)

The 2014-15 year Commissioning for Quality and Innovation (CQUIN) is collected and submitted on a quarterly basis and reported back to the CCG a quarter later (for example, quarter one data is available at the start of quarter three). CQUINs enable commissioners to reward excellence, by linking a proportion of a healthcare providers' income to the achievements of a local quality improvement goal. Progress in quarters one and two was good, with the Learning Disability area particularly reporting very positive work and embedding of good practice to improve patient care and people's experiences.

3.8.1.5. Safeguarding children and looked after children

The CCG has a statutory duty to safeguarding children and adults. In June 2012, Ofsted and the Care Quality Commission (CQC) undertook a joint inspection of Barnsley's Safeguarding and Looked-After Children (LAC) Services. Whilst the inspection did not identify any evidence of harm to children in need or requiring protection, overall the rating was inadequate. This rating resulted in an Improvement Notice being issued in November 2012 by the Secretary of State for Education.

Ofsted undertook a single inspection of Safeguarding Children and LAC Services in the Local Authority in June 2014 and as a result of the improvement seen during the inspection the Improvement Notice was lifted by the Secretary of State in November 2014. The responsibility of monitoring the Continuous Service Improvement plan now lies with Barnsley Safeguarding Children Board.

Barnsley CCG was notified on Thursday 13 November 2014 by the CQC that they planned to conduct a week-long review of services for LAC and Safeguarding in Barnsley commencing Monday 17 November. The inspectors found nothing of concern throughout the week that required immediate remediation. They reported that they judged that the CCG had good leadership in place.

Following the publication of the Jay report in August 2014 which outlined historic inadequate action identified in Rotherham in relation to Child Sexual Exploitation (CSE) the CCG Governing Body requested monthly update reports on the situation in Barnsley. Barnsley is sadly not exempt from CSE activity and so, in the light of the Jay report and the Casey Report February 2015 the Barnsley Safeguarding Children Board (BSCB) has prioritised briefing about such activity to its meetings. The local offender profile is still perceived to be mainly white males late teens to early 50's, the majority of cases relate to one perpetrator and one victim. There is still no evidence of any gang related activity in Barnsley. Most of the victims are white females under the age of 16 years.

3.8.1.6. Safeguarding adults

As commissioners of care and partners in the Barnsley Safeguarding Adults Board the CCG have a key role in the safeguarding of adults. We meet with the Care Quality Commission (CQC) and the local authority on a monthly basis to share intelligence particularly in relation to care homes.

Safe and well checks are undertaken for any Continuing Healthcare patients in a home where there are concerns about standards of care. We also provide professional advice to the local authority in relation to any contractual actions they may need to take. It is recognised that the standard of care in care homes will be a key focus going forward.

The Prevent agenda is to be strengthened next year with the mandate that all providers will have a statutory duty to comply with the Prevent Strategy. A Mental Capacity Act and Deprivation of Liberty five-year strategy has been developed with the local authority.

3.8.1.7. Patient stories

Patient stories continue to be a successful and positive contribution to Governing Body meetings. They are tailored to the agenda and reflect current issues for Barnsley people. They are filmed and are available on the CCG website: www.barnsleyccg.nhs.uk. We intend to review the effectiveness of this approach in 2015-16.

3.8.1.8. Friends and Family

The Friends and Family response rate at Barnsley Hospital is 40% for inpatients and 25% for A&E. This is higher than the average for the region. Levels of satisfaction have remained high though this will be reported differently in 2015.

The Friends and Family Test is to be expanded in 2015 to include Outpatients, Walk-in Centres, Ambulance Services, Mental Health Services and primary medical services.

3.8.1.9. Complaints

Barnsley CCG welcomes all comments and feedback about the CCG and its role in commissioning services on behalf of the people of Barnsley. We strive to resolve complaints through a personal, accessible and flexible approach, ensuring lessons are learned and good practice is shared.

The CCG also has a role in signposting people to the appropriate providers of NHS care regarding complaints and ensuring people are aware of both the provider's advocacy systems and the national independent advocacy service Voiceability.

The majority of contacts made to the CCG are of a signposting nature, with only a minority of contacts and complaints referring specifically to the CCG's role. These have tended to be queries and clarifications regarding clinical procedures that the CCG commissions.

During the past year the team has received 34 complaints of which 18 complaints have been signposted to other organisations for them to lead and investigate. Of the remaining 16 complaints, 14 were investigated by the CCG. The remaining two were provider-led and were responded directly by the services involved.

3.9. Compliance with statutory duties

We certify that the clinical commissioning group has complied with the statutory duties laid down in the NHS Act 2006 (as amended by the Health & Social Care Act 2012). For details see the Governance Statement, section 6.9.6.

3.10. Environmental issues

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. At Barnsley CCG we acknowledge our responsibility to our patients, local communities and the environment and are committed to work hard to minimise our carbon footprint.

During 2014-15 the CCG has put in place a Sustainable Development Strategy and Management Plan, available on our website, which describes our commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner.

3.11. Environmental issues and sustainability report

Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. At Barnsley CCG we acknowledge our responsibility to our patients, local communities and the environment and are committed to work hard to minimise our carbon footprint.

During 2014/15 the CCG has put in place a Sustainable Development Strategy and Management Plan, available on our website, which describes our commitment to promoting environmental and social sustainability through our actions as a corporate body as well as a commissioner.

NHS Property Services (NHSPS) owns Hillder House on Gawber Road, which is the operating base for Barnsley CCG. We work closely with NHSPS to improve our building, Hillder House. For example, modern electronic fittings have been renewed throughout the building, and low-energy lighting has been installed to reduce consumption. Facilities have been provided for staff to recycle paper, toner, and printer cartridges.

Over the last year the CCG has encouraged all our staff to be mindful of the need to minimise our impact on the environment. We have:

- Installed a shower and bike racks in Hillder House and introduced a ‘bikes to work scheme’ to enable our staff to cycle to work, enabling them to stay healthy and reduce our carbon emissions at the same time

- Encouraged staff to save energy by switching off lights and computers when they are not using them
- Promoted car sharing or even walking to meetings where this is possible.

We also use our influence as a commissioner to ensure our providers are delivering their own stretching carbon reduction targets. The overall direction of travel in terms of our commissioning priorities is towards a reduction in secondary-care admissions, with more services being delivered closer to home in primary or community settings, which should reduce costly journeys as well as being better for local people.

3.12. Social, community issues and human rights issues and policies

Barnsley CCG is fully committed to complying with the Public Sector Equality Duty (PSED) set out in the Equality Act 2010, both as an employer and a commissioner of health services for the people of Barnsley. The CCG has an Equality Objectives Action Plan, which is developed and monitored by Equality Steering Group (ESG). ESG is chaired by the Chief Nurse, and has members from across the CCG's functions. A representative from Healthwatch Barnsley attends to make sure the patient's viewpoint is heard. The CCG has a full suite of human resources in place, all of which are supported by robust Equality Impact Assessments (EIA). We provide equality and diversity training for all our staff, and promote our values and expected behaviours through our performance management arrangements. The CCG undertakes regular staff surveys and takes action where issues are identified.

3.13. Equality and diversity report

The PSED places an obligation on public bodies including our CCG to proactively improve equality for people with one or more protected characteristics. It aims to help public authorities avoid discriminatory practices and integrate equality into core business. It is made up of a general duty and specific duties. The general duty is the main part of the legislation with the specific duties supporting public bodies to demonstrate performance and compliance.

The general duty

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity
- Foster good relations.

Specific duties

- **Equality objectives –** The Act requires public bodies like the CCG to prepare and publish one or more specific and measurable equality objectives which they believe will support them to achieve the aims of the general duty

- **Publication of information –** Annually the CCG must publish information which describes the key inequalities experienced by people with protected characteristic(s) and which demonstrates the impact of its policies and practices on people with protected characteristics.

The CCG has established an Equality Steering Group, chaired by the Chief Nurse, which reports to the Governing Body. We have been using the national refreshed Equality Delivery System (EDS 2), a system designed to support our organisation in our commissioning role and our providers of services to deliver better outcomes for their local population and better working environments for staff which are personal, fair and diverse.

Our Governing Body has approved our equality objectives that have been developed and supported by underpinning actions that are linked to the four EDS goals.

- Make effective use of equality data within the commissioning cycle to prioritise commissioning of services and embed equality within provider contracts

- Ensure appropriate and accessible targeted communication with local communities to facilitate improved access and patient experience

- Consistency of equality approach across the CCG in respect of equality leadership, staff empowerment and access to development opportunities

- Demonstrate leadership in advancing the equality agenda internally and with partners and providers to ensure inequalities are addressed within a partner approach to ensure equity of access experience and outcomes for patients.

Our CCG has gathered information to show the key inequalities experienced by local people which is published on our website http://www.barnsleyccg.nhs.uk/about-us/equality-and-diversity.htm.

The CCG is, as are all public bodies, required to meet the requirements of the **2010 Equality Act** and is committed to making sure that equality and diversity is a priority when planning and commissioning local healthcare services. To enable us to do this most effectively our engagement strategy highlights the most appropriate ways to work with local communities and relevant groups, dependent on the focus required, to best understand their needs and

how to utilise this intelligence to either require improvements in existing services from the relevant provider or to scope and remediate unmet need.

To ensure that our staff members do not experience discrimination, harassment and victimisation we have adopted a range of policies which are available on our website:

- Annual Leave and Special Leave
- Disciplinary Policy
- Equality and Diversity and Human Rights Strategy
- Equality Impact Assessment Policy.

Equality Impact Assessments have been carried out on all our policies, and over the next year we will be monitoring the impact of the implementation of our workforce policies on our staff to ensure that we are proactively identifying and addressing any inadvertent inequalities that may emerge. From April 2015 primary medical services will be required to submit Equality Impact Assessments and the CCG will support this work.

CCG staff members have participated in mandatory equality and diversity training via an e-learning course. A bespoke training session was held for senior management team members and staff directly involved in commissioning. This described the implications of the Public Sector Equality Duty in commissioning health services.

The CCG recognises that in order to remove the barriers experienced by disabled people, we need to make reasonable adjustments for any of our employees who declare a disability. We do this on a case by case basis and involve occupational health services as appropriate.

We have reviewed and updated our equality objectives and plans in line with refreshed EDS 2.

At the end of the financial year, six of the 15 members of the Governing Body are women and nine are men. There are 14 men and 67 women employed throughout the rest of the organisation.

3.14. Employee matters

The CCG has invested a significant amount in ensuring employees have a positive and productive working environment throughout the course of 2014-15.

Some examples of the work undertaken are:

- Training in relation to the new Performance Development Review (PDR) process which is based around the CCG values and behaviours

- Training in relation to Safer Recruitment for senior managers within the organisation to ensure increased governance around recruitment processes
- The introduction of values-based recruitment within the CCG
- Introduction of a full suite of HR policies and significant communications to ensure these have been embedded across the organisation
- Briefings for all staff in relation to upcoming changes to the NHS Pensions Scheme.

Further workforce initiatives are planned for 2015-16 to continue to develop Barnsley CCG as an employer of first choice.

3.14.1. Gender breakdown of all our staff

As at 31st March 2015, the CCG employs 95 people. The table below sets out the gender breakdown of all CCG staff.

	Male	Female
Governing Body	9	6
Senior managers*	8	25
Other staff	5	42
Total	22	73

*The definition of senior managers was agreed at Band 8A and above for the purposes of this data.

3.15. Our future plans, performance and objectives

There are a range of external factors which influence and could impact upon our future plans, objectives and priorities such as the changes in national policy.

One of these developments in 2014-15 was the publication of the NHS Five Year Forward View and therefore our refreshed Strategic Commissioning Plan, whilst reconfirming our vision, values and objectives, sets out our response to this and begins to describe a strategic direction of travel towards 'Out of Hospital' care (where this is safe and better for the patient) and developing new models of care which are able to respond to the challenges of this direction of travel.

Another key development which emerged during 2014-15 was the opportunity to receive delegated commissioning responsibility for primary medical services. A key strand of our future plans is therefore to integrate the commissioning of primary medical services into our work. This will enable us to commission services right through the care pathway with the

patient placed at the centre of the process and ensure that capacity is in the right place to meet shifting demands and changes in patterns aligned to the direction of travel towards out-of-hospital care.

We see service transformation as the key to ensuring whole system change and delivery of new models of care. This reflects the view set out in the Call to Action that transformation of health services is essential to ensure a sustainable NHS. We will therefore be establishing a Clinical Transformation Board (CTB) in 2015-16 to lead the development and delivery of our service transformation and commissioning priorities across the CCG.

The key functions of the CTB will include the development of service transformation, pathway redesign, commissioning for improved outcomes, quality improvement through service redesign, reducing health inequalities and prevention, providing clinical leadership to integrated commissioning and service transformation, and, evaluation of transformation programmes, ensuring benefits realisation and informing future years commissioning

Initially there will be a small number of work streams designed to deliver transformational service change across Barnsley. The golden thread running through each of the work streams will include personalisation and care closer to home. The work streams will include:

- Community Services
- Care Homes and Older People
- Primary Care
- Service and Pathway Redesign including acute services
- Prevention, Awareness, Public Campaigns and Behavioural Change

Our plans will enable us to continue to move towards our vision for health and healthcare services in Barnsley whilst continuing to ensure that the services we provide meet the needs of Barnsley people and provide them with access to healthcare which meets the pledges and commitments of the NHS Constitution

Signed on behalf of NHS Barnsley CCG by Lesley Smith, Accountable Officer, on 21 May 2015

4. The Members' report

4.1. Our Membership Body and Governing Body, including:

4.1.1. Our member practices

Clinical commissioning groups are member organisations. Representatives from the 36 GP practices across Barnsley form the NHS Barnsley CCG Membership Council. Details of all our practices are on our website: www.barnsleyccg.nhs.uk/about-us/membership.

4.1.2. Our Governing Body

As set out in the Health and Social Care Act 2012, each CCG must have a Governing Body. The Governing Body of the CCG provides oversight and assurance as well as giving strategic direction to the CCG's activities.

During 2014-15 the members of our Governing Body were as shown below. All appointments were made in line with regulations and guidance as well as the requirements of the CCG's Constitution.

The Governing Body is made up of 15 people including eight members elected by the Membership Council; two Lay Members; a GP Practice Manager; a Secondary Care Clinician; a Chief Nurse; and two other senior executive officers as follows:

Name	Position on the Governing Body	Appointment dates	Attendance record
Dr Nick Balac	Elected Member & Chair of the CCG	1 April 2013	13/13 (100%)
Dr Mehrban Ghani	Elected Member & Medical Director	1 April 2013	13/13 (100%)
Dr Clare Bannon	Elected Member	1 April 2013	10/13 (77%)
Dr Robert Farmer	Elected Member	1 April 2013	11/13 (85%)
Dr John Harban	Elected Member	1 April 2013	13/13 (100%)
Dr Sudhagar Krishnasamy	Elected Member	1 April 2013	12/13 (92%)
Mr James Logan	Elected Member	1 April 2013	12/13 (92%)
Dr Nick Luscombe	Elected Member	1 April 2013	11/13 (85%)
Ms Anne Arnold	Lay Member Representative for Governance	1 April 2013	11/13 (85%)

Name	Position on the Governing Body	Appointment dates	Attendance record
Mr Chris Ruddlesdin	Lay Member Representative for Patient and Public Engagement	1 April 2013	11/13 (85%)
Ms Marie Hoyle	Practice Manager Member	1 April 2013	12/13 (92%)
Mr Mike Simms	Secondary Care Clinician	1 September 2013	11/13 (85%)
Ms Brigid Reid	Chief Nurse	1 April 2013	13/13 (100%)*
Mr Mark Wilkinson	Chief Officer and Accountable Officer	1 April 2013 (left CCG 27 July 2014)	4/4 (100%)
Ms Lesley Smith	Interim Chief Officer and Accountable Officer	28 July 2014	8/8 (100%)
Ms Cheryl Hobson	Chief Finance Officer	1 April 2013 (left on secondment 20 February 2015)	11/12 (92%)
Ms Heather Wells	Chief Finance Officer	23 February 2015	1/1 (100%)

*At two meetings the Deputy Chief Nurse attended as the Acting Chief Nurse during a period of absence, therefore the % attendance shown is for the post

4.1.3. Governing Body profiles and conflicts of interest

Profiles of the Governing Body members, details of conflicts of interest they have declared, and other relevant information can be found in the Remuneration Report (section 5.8).

4.1.4. Committees of the Governing Body

All CCG's are required to have an Audit Committee and a Remuneration Committee. In addition, although not stipulated in legislation, we have also established the following:

- Quality and Patient Safety Committee
- Patient and Public Engagement Committee
- Finance and Performance Committee
- Equality Steering Group.

Details of the functions, membership, and attendance records of each of these committees can be found in the Governance Statement (section 6.4).

The CCG's Audit Committee is a statutory committee of the Governing Body. The Chief Officer and the CCG Chair attend the committee at least once a year to answer questions in relation to internal controls and assurance.

4.1.5. Political or charitable donations

The CCG has not made any political or charitable donations in 2014-15.

4.2. Pension liabilities

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations. Details of how pensions liabilities are accounted for can be seen in Note 4.5 (page 19) of the Accounts appended to this Annual Report.

4.3. Sickness absence data

Monthly workforce reports provide an up to date picture of sickness absence. They also provide a sickness triggers report which prompts management action and discussion with the individual in order to manage the situation and provide supportive action before the matter escalates. Additional support, advice and interventions can also be facilitated through Occupational Health if required. The annual sickness absence rate for the CCG is disclosed at Note 4.3 (page 17) of the annual accounts.

4.4. External Auditor's remuneration

The CCG's external auditors are KPMG LLP. The audit fees for the statutory accounts for 2014-15 were £90,000 gross. No additional fees were levied for other services.

4.5. Disclosure of "serious untoward incidents" relating to disclosure of confidential data

As detailed in the Governance Statement, there were no serious incidents involving data loss or confidentiality breaches.

4.6. Cost allocation and setting of charges for information

The CCG is committed to responding constructively to requests from members of the public for access to information, either under the Freedom of Information Act 2000 or the Data Protection Act 1998. Details of how to make a Freedom of Information request are available on the CCG's website. Although there is provision in the CCG's policies to levy a small charge to cover the cost of retrieving the information, the CCG does not normally charge for responding to such requests.

We certify that the CCG has complied with HM Treasury's guidance on setting charges for information.

4.7. Principles for remedy

The CCG continues to be guided by the principles for remedy in consideration of complaints handling. For more information on these principles, visit: www.ombudsman.org.uk.

Good practice with regard to remedies means:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement.

4.8. Employee consultation

We have established a variety of mechanisms for provision of information to and consultation with employees, including team meetings, briefings and bulletins via the organisations intranet, internal email systems, team meetings and 1:1 meetings.

Additionally, support is provided via Yorkshire and Humber Commissioning Support in relation to the partnership working with staff side and the dissemination of national guidance.

We have an established Organisational Change Policy in place to manage any matters that may require formal legal consultation with employees.

Any national changes are communicated in partnership between the organisation and staff side, for example over the course of the last few months we have held a significant number of briefings around changes to the NHS Pension Scheme with CCG and local practice staff.

4.9. Disabled employees

The table below shows employees who have declared a disability as of 31st March 2015. Please note 'not declared' means that employees have specifically chosen not to declare this information whereas 'undefined' should be classified as a null return.

No	Not declared	Undefined	Yes
80	11		4

All of our policies are equality impact assessed and relevant action plans are produced where required to ensure there is no discrimination. The recruitment policy and processes make provisions for adequate adjustments to be made for individuals with a disability and the internal policies around health, safety and sickness have provision for adjustments to be made as necessary.

4.10. Emergency preparedness, resilience and response

Emergency planning is all about being prepared and ready to provide a rapid, effective response to major incidents which may happen in our area, responding to patient need and helping protect the health of local people.

The CCG has put in place Business Continuity and Emergency Preparedness policies, and works closely with other bodies across South Yorkshire and Bassetlaw to ensure that they also have plans in place and that these are periodically tested in the event of a major incident such as a pandemic.

The CCG has taken part in a regional Ebola planning event in November 2014 and will be taking part in a local Pandemic Flu exercise, exercise 'Alberio', with partners from the South Yorkshire Local Resilience Forum and Local Health and Resilience Partnership on 21 April 2015. This provided a further opportunity to test communication and decision making across the NHS in South Yorkshire and within the tactical-level, district multi-agency groups based on local authority boundaries and provided assurance that the arrangements are robust.

We will continually update our plans in light of the lessons learnt from these exercises, and provide further training for staff to update their skills and knowledge.

Within the CCG, a desk top exercise has also been undertaken to test business continuity plans and arrangements and further exercises will be planned as appropriate.

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

4.11. Health and safety

The CCG's arrangements in respect to Health and Safety are described in the Governance Statement (section 6.5.3).

4.12. Fraud

The CCG's arrangements in respect to countering the risk of fraud and corruption are described in the Governance Statement (section 6.5.3).

4.13. Statement as to disclosure to Auditors

Each individual who is a member of the Governing Body at the time of the Member's report is approved confirms:

So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,

That the member has taken all steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

Signed on behalf of NHS Barnsley CCG by Lesley Smith, Accountable Officer, on 21 May 2015

5. Remuneration report

5.1. Remuneration Committee report

The Health and Social Care Act 2012, 1631 requires that each clinical commissioning group must have a Remuneration Committee. In accordance with this requirement, the CCG established a Remuneration Committee in April 2013. The Committee was established in accordance with the guidance and the terms of reference were developed using the NHS England guidance and template, and approved by the Governing Body in April 2013. The terms of reference were subsequently reviewed and approved by the Governing Body in June 2014. The Committee has met six times during the year to agree and recommend the Remuneration and Terms of Services for the Governing Body members and any other members of staff not on Agenda for Change terms and conditions.

Details of the members of the Remuneration Committee and their attendance can be found in section 6.4.3.

5.2. Policy on remuneration of senior managers

The CCG has not developed a specific Remuneration Policy but used the guidance outlined in the Department of Health July 2012 Pay Framework for Very Senior Managers in Health Strategic and Special Health Authorities, Primary Care Trusts and Ambulance Trusts where appropriate in the absence of specific guidance for CCG's for some VSM roles. The CCG has utilised the CCG specific guidance in relation to Chief Officer and Chief Finance Officer remuneration.

5.3. Senior managers performance related pay

The CCG has not implemented any performance related pay.

5.4. Policy on senior managers' contracts

As at 31 March 2015 the Chief Officer, Chief Finance Officer, and Chief Nurse are all on permanent contracts of employment. As noted at section 5.7 the Chief Finance Officer is currently on long term secondment from the CCG. Her successor in the role was paid on an off payroll arrangement until 31 March 2015 before going on payroll from 1 April 2015.

Other senior managers within the CCG are either on contracts of employment or contracts for services. When determining the most appropriate type of contract for senior managers advice is provided via the Yorkshire and Humber Commissioning Support Human Resources team.

5.5. Senior managers service contracts

Senior managers acting in officer roles on the Governing Body hold permanent contracts whilst other Governing Body members hold fixed term contracts aligned to the constitution and standing orders of the CCG.

The elected members were employed as of 1 April 2013, including the Chair and Medical Director. All members can stand for re-election up to a maximum of seven years' service. The Governing Body positions of Clinical Chair and Medical Director were for a four-year term as specified in the CCG's constitution. Other elected members were allocated different terms of office as follows:

- Four-year term: Dr Nick Luscombe, Dr Clare Bannon, Dr Sudhagar Krishnasamy
- Two-year term: Dr John Harban, Dr Robert Farmer, Mr Jim Logan.

Three of the Governing Body members have Contracts for Services: Anne Arnold (Lay Member, three-year term); Chris Ruddlesdin (Lay Member, two-year term) and Mike Sims (Secondary Care Clinician, two-year term). The practice manager member, Marie Hoyle, is seconded from her practice one day per week.

5.6. Payments to senior managers

Section 5.6 is covered by the external auditor's opinion.

There have been no payments for loss of office and no other payments to past senior managers.

5.6.1. Salaries and allowances (information subject to audit)

	2014 - 15						2013 – 14					
	Salary & Fees	**Taxable Benefits**	**Annual Performance related Bonuses**	**Long-term Performance Related Bonuses**	**All Pension Related Benefits**	**Total**	Salary & Fees	Taxable Benefits	Annual Performance related Bonuses	Long-term Performance Related Bonuses	All Pension Related Benefits	Total
	(bands of £5k)	**(to Nearest £00)**	**(bands of £5k)**	**(bands of £5k)**	**(bands of £2.5k)**	**(bands of £5k)**	(bands of £5k)	(to Nearest £00)	(bands of £5k)	(bands of £5k)	(bands of £2.5k)	(bands of £5k)
Name and title	**£000**	**£00**	**£00**	**£000**	**£000**	**£000**	£000	£00	£00	£000	£000	£000
Dr N Balac, Chairman	**75 - 80**	**0**	**0**	**0**	**0 - 2.5**	**80 - 85**	75 - 80	0	0	0	0	75 - 80
M Wilkinson (Left 27 July 2014), Chief Officer	**40 - 45**	**0**	**0**	**0**	**0**	**25 - 30**	125 - 130	0	0	0	17.5 - 20	140 - 145
L J Smith, (Commenced 28 July 2014) Chief Officer (Notes 2&3)	**95 - 100**	**0**	**0**	**0**	**0**	**95 - 100**	0	0	0	0	0	0
Dr M Ghani, Medical Director	**95 - 100**	**0**	**0**	**0**	**22.5 - 25**	**120 - 125**	75 - 80	0	0	0	0	75 - 80
C Hobson, (to 20 February 2015) (Note 4) Chief Finance Officer	**85 - 90**	**0**	**0**	**0**	**0**	**85 - 90**	95 - 100	0	0	0	12.5 - 15	105 - 110
H Wells, (Commenced 20 February 2015) (Notes 2&3) Chief Finance Officer	**45 - 50**	**0**	**0**	**0**	**0**	**45 - 50**	0	0	0	0	0	0
B Reid, Chief Nurse	**85 - 90**	**0**	**0**	**0**	**95 - 97.5**	**180 - 185**	80 - 85	0	0	0	10 - 12.5	90 - 95
K Martin, (Commenced 1 November 2014 to 28 February 2015) (Note 2) Acting Chief Nurse	**70 - 75**	**0**	**0**	**0**	**10 - 12.5**	**80 - 85**	0	0	0	0	0	0
Dr C Bannon, Governing Body Member	**40 - 45**	**0**	**0**	**0**	**7.5 - 10**	**45 - 50**	30 - 35	0	0	0	0	30 - 35
Dr J Harban, Governing Body Member	**25 - 30**	**0**	**0**	**0**	**137.5 - 140**	**165 - 170**	25 - 30	0	0	0	0	25 - 30

Salaries and allowances cont.	**2014 - 15**						2013 – 14					
	Salary & Fees	**Taxable Benefits**	**Annual Performance related Bonuses**	**Long-term Performance Related Bonuses**	**All Pension Related Benefits**	**Total**	Salary & Fees	Taxable Benefits	Annual Performance related Bonuses	Long-term Performance Related Bonuses	All Pension Related Benefits	Total
	(bands of £5k)	**(to Nearest £00)**	**(bands of £5k)**	**(bands of £5k)**	**(bands of £2.5k)**	**(bands of £5k)**	(bands of £5k)	(to Nearest £00)	(bands of £5k)	(bands of £5k)	(bands of £2.5k)	(bands of £5k)
Name and title	**£000**	**£00**	**£00**	**£000**	**£000**	**£000**	£000	£00	£00	£000	£000	£000
Dr N Luscombe, Governing Body Member	**25 - 30**	**0**	**0**	**0**	**260 - 262.5**	**290 - 295**	25 - 30	0	0	0	0	25 - 30
M Hoyle, (Note 1) Governing Body Member (Practice Manager)	**15 - 20**	**0**	**0**	**0**	**0**	**15 - 20**	15 - 20	0	0	0	0	15 - 20
J Logan, Governing Body Member	**25 - 30**	**0**	**0**	**0**	**0**	**25 - 30**	25 - 30	0	0	0	0	25 - 30
Dr R Farmer, Governing Body Member	**25 - 30**	**0**	**0**	**0**	**165 - 167.5**	**190 - 195**	25 - 30	0	0	0	0	25 - 30
Dr S Krishnasamy, Governing Body Member	**25 - 30**	**0**	**0**	**0**	**127.5 - 130**	**155 - 160**	25 - 30	0	0	0	0	25 - 30
Dr M Simms, Secondary Care Doctor, Governing Body Member	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**	5 - 10	0	0	0	0	5 - 10
C Ruddlessdin, Lay Member for Public and Patient Engagement	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**	10 - 15	0	0	0	0	10 - 15
A Arnold, Lay Member Representative for Governance	**10 - 15**	**0**	**0**	**0**	**0**	**10 - 15**	10 - 15	0	0	0	0	10 - 15

* Consent Withheld '- Information Not Provided

Note 1: M Hoyle is seconded as a Governing Body member from the Kakoty practice and is therefore not paid directly by the CCG.

Note 2: Remuneration for K Martin, H Wells and L Smith reflects work paid for other than as a director.

Note 3: Remuneration for L Smith and H Wells excludes VAT paid on invoices submitted for work undertaken.

Note 4: Pension related benefits for C Hobson include transferred in values so are excluded from this report.

5.6.2. Pension benefits of senior management (information subject to audit)

Pension entitlements 2014-15	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension (rounded to nearest £00)
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£'00**
Dr N Balac, Chairman	**0 - 2.5**	**0 - 2.5**	**10 - 15**	**35 - 40**	**243**	**229**	**8**	**0**
M Wilkinson, (Left 27 July 2014) Chief Officer	**-2.5 - 0**	**-2.5 - 0**	**40 - 45**	**130 - 135**	**754**	**737**	**-1**	**0**
L J Smith, (Commenced 1 March 2015)* Chief Officer	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Dr M Ghani, Medical Director	**0 - 2.5**	**2.5 - 5**	**5 - 10**	**25 - 30**	**130**	**110**	**17**	**0**
C Hobson, (to 20 February 2015)** Chief Finance Officer	**47.5 - 50**	**0 - 2.5**	**55 - 60**	**0 - 5**	**697**	**24**	**600**	**0**
B Reid, Chief Nurse	**0 - 2.5**	**5 – 7.5**	**25 - 30**	**75 - 80**	**489**	**430*** **	**47**	**0**
K Martin, (Commenced 1 November 2014 to 28 February 2015) Acting Chief Nurse	**0 - 2.5**	**0 - 2.5**	**25 - 30**	**80 - 85**	**489**	**456**	**7**	**0**
Dr C Bannon, Governing Body Member	**0 - 2.5**	**0 - 2.5**	**0 - 5**	**0 - 5**	**4**	**0**	**4**	**0**
Dr J Harban, Governing Body Member	**5 - 7.5**	**17.5 - 20**	**5 - 10**	**25 - 30**	**185**	**72**	**112**	**0**
Dr N Luscombe, Governing Body Member	**10 - 12.5**	**32.5 - 35**	**10 - 15**	**40 - 45**	**254**	**60**	**193**	**0**

Pension entitlements 2014-15 cont.	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2015	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real increase in Cash Equivalent Transfer Value	Employer's contribution to stakeholder pension (rounded to nearest £00)
	(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
Name and title	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£'00**
Dr R Farmer, Governing Body Member	**5 - 7.5**	**20 - 22.5**	**5 - 10**	**25 - 30**	**131**	**26**	**104**	**0**
Dr S Krishnasamy	**5 - 7.5**	**15 - 17.5**	**5 - 10**	**20 - 25**	**89**	**21**	**68**	**0**

*Member has opted not to join the NHS Pension Scheme following commencement
**Member has transferred pension benefits to the NHS Pension Scheme in 14/15
*** Prior year comparator has changed due to changed information provided from NHS Pensions Agency.

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

Real Increase in CETV

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

5.6.3. Pay multiples (information subject to audit)

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

The banded remuneration of the highest paid director in Barnsley Clinical Commissioning Group in the financial year 2014-15 was £97,500 (2013-14, £127,500). This was 3.4 times (2013-14, 4.2 times) the median remuneration of the workforce, which was £28,900 (2013-14, £30,261). This reduction is due to two individuals filling the post of Chief Officer in year and therefore only part year costs being reflected. In 2014-15, 0 (2013-14, 0) employees received remuneration in excess of the highest-paid director. Remuneration from £0 to £0.

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

5.7. Off-payroll engagements

It is a Treasury requirement for public sector bodies to report arrangements whereby individuals are paid through their own companies, and so are responsible for their own tax and NI arrangements. Payments to GP Practices for the services of employees and GPs are deemed to be 'off payroll engagements' and are therefore subject to these disclosure requirements. Off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2015	2
Of which, the number that have existed:	
• For less than one year at the time of reporting	1
• For between one and two years at the time of reporting	1
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	0
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2015	**2**

The arrangement that has existed for between one and two years at the time of reporting relates to the Practice Manager Member of the Governing Body who is paid through the payroll of her practice which ensures appropriate deductions are made in respect of tax, NI, and pension.

Two new off payroll engagements occurred in the year. These are detailed in the table below:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	2
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	2
Number for whom assurance has been requested	2
Of which, the number:	
• For whom assurance has been received	2
• For whom assurance has not been received	0
• That have been terminated as a result of assurance not being received	0

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

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	2
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	3

The Clinical Chair, Chief Officer (as Accountable Officer) and the Chief Finance Officer are the three members of the Governing Body deemed to have significant financial responsibility for the purposes of the table above.

- The Clinical Chair was paid through the payroll throughout 2014-15.
- Following the departure of the former Chief Officer in July 2014, his replacement was initially employed on an interim basis. She was paid on an off payroll arrangement during this interim period, but was paid through the payroll from 1 March 2015 following her appointment on a substantive basis in February 2015.
- The Chief Finance Officer is on long term secondment from the CCG from February 2015. Her successor in the role was paid on an off payroll arrangement until 31 March 2015 before going on payroll from 1 April 2015.

5.8. Membership and Governing Body profiles, including declarations of interests

All our Governing Body members live or work locally, so they all have a real interest in making sure that health care services for the people of Barnsley are the best that they can be. The Governing Body is made up of 15 people including: GPs; a nurse; two lay members of the public; GP practice and business manager; a secondary care consultant and senior officers.

Dr Nick Balac, Elected Member and Chair of the CCG

Chair of Finance and Performance Committee; Member of Patient and Public Engagement Committee and Remuneration Committee

In October 2012 I became Chair of Barnsley CCG. I am strongly committed to improving the quality of patient care, working in collaborative relationships with partners. My aspiration is to reduce local health inequalities through maximising clinical and public engagement.

Anne Arnold, Lay Member Representative for Governance

Chair of Audit Committee; Chair of Remuneration Committee; Member of Finance and Performance Committee

I have been appointed as lay member for governance and am now a family carer but have extensive experience of working in the NHS as well as central and local government. I am a qualified CPFA accountant and hold a Masters Degree in Business Administration as well as qualifications in Health Economics and Public Administration.

Dr Clare Bannon, Elected Member

Member of Patient and Public Engagement Committee and Equality Steering Group

Since qualifying as a GP and gaining the MRCGP in 2009, I have worked at the Dove Valley Practice in Worsbrough, of which I am now a partner. I have a particular interest in family planning services and dermatology. My role with the CCG is varied and I currently lead on children's and maternity services, planned care and patient and public engagement.

Dr Robert Farmer, Elected Member

Member of Quality and Patient Safety Committee

I have been a full time partner at Walderslade Surgery in Hoyland for 14 years, I have a particular interest in long-term conditions and the use of risk stratification tools to improve the delivery of care to patients.

Dr Mehrban Ghani, Elected Member and Medical Director

Chair of Quality and Patient Safety Committee

I have been working as a GP in Barnsley since 2004 and am currently a partner at the White Rose Medical Practice in Cudworth. I was also a previous GP Tutor for NHS Barnsley Primary Care Trust leading on revalidation. My role in the CCG is as the Medical Director working closely with senior management and clinical colleagues.

Dr John Harban, Elected Member

Member of Finance and Performance Committee and Remuneration Committee

I have been a GP in Barnsley for 22 years having trained at Sheffield Medical School, qualifying in 1986. As well as doing general practice, I have been the club doctor at Barnsley Football Club for the last 12 years. Alongside this I was team doctor for the Football Association looking after the international team's age group of 16 to 20. I am the lead GP looking at cancer in the CCG and I sit on the finance and performance committee. Also I am the joint contracting lead for acute contracts.

Cheryl Hobson, Chief Finance Officer (April 14 – February 15)

Member of Finance and Performance Committee and Equality Steering Group

A CIPFA qualified accountant, I have spent most of my career to date in local government. Senior roles having included the Assistant Director of Social Services at Barnsley MBC from 1999 to 2001 and more recently the Assistant Director of Family Services, Children's Commissioning at Wakefield MBC. My previous roles have presented interesting challenges

across areas as diverse as Social Services finances, developing strategies for multi-million pound school investments and transformation programmes involving health and social care services. I joined Barnsley CCG as Chief Finance Officer in January 2013.

Heather Wells, Chief Finance Officer (February 15 – March 15)

Member of Finance and Performance Committee and Equality Steering Group

I am a Chartered Accountant with extensive experience at Board level, both in the NHS and the not-for-profit sector. My NHS experience includes 16 years in the Leeds health economy, with five years as Director of Finance at Leeds North West Primary Care Trust. More recently, I have worked with a number of NHS bodies on a consultancy/interim basis, including NHS England and CCGs in both West and South Yorkshire.

I am passionate about building highly-performing teams and look forward to supporting the delivery of high-quality, cost-effective services for the people of Barnsley.

Marie Hoyle, Practice Manager Member

Member of Audit Committee; Patient and Public Engagement Committee; Equality Steering Group; and Remuneration Committee

I have more than 25 years' service within the NHS in Barnsley, more than 20 years of which is in primary care management as the Practice Business Manager at The Kakoty Practice.

I am keen to utilise modern technologies to improve services and access to services, having piloted online GP appointment booking in 2002 and subsequent expansion of available online. I have high involvement with the local practice manager group and I am the link between them and the CCG Governing Body.

In 2015 I was supported by the CCG to undertake the NHS Leadership Academy Nye Bevan Programme, participation in which has broadened my understanding of effective collaborative working.

Dr Sudhagar Krishnasamy, Elected Member

Member of Quality and Patient Safety Committee

I graduated from the Barnsley Vocational Training Scheme and have been working in Barnsley for the past 10 years. I lead on unplanned care for the CCG. My aim is to help the CCG provide a high quality, sustainable, cost effective services for the people of Barnsley, care closer to home wherever possible by working in collaboration with the local partners and the public. I am a member of the Quality and Patient Safety Committee. Apart from CCG work, I am a GP Appraiser and executive member of the Local Medical Committee.

James Logan, Elected Member

Member of Audit Committee and Finance and Performance Committee

My professional career began with the National Coal Board. When the mines closed I took up a post in primary care as Business Manager at a large training GP practice where we piloted many of the IT initiatives for the NHS. We produced many changes to services from secondary to primary/community care as well as making large savings on our budget.

Dr Nick Luscombe, Elected Member

Member of Finance and Performance Committee and Remuneration Committee

I qualified at Cambridge's clinical school in 1986 where I saw medicine years ahead of anything I had seen locally. I did my GP training in Sheffield and have worked in a variety of hospitals and specialities including the military before becoming a GP partner at the Huddersfield Road practice in 1999.

My interest is medical teaching. My ambition is simple, to try and get Barnsley's healthcare up to world class standards.

Brigid Reid, Chief Nurse

Chair of Equality Steering Group; member of Patient and Public Engagement Committee and Quality and Patient Safety Committee

I have over 30 years' experience as a nurse working in both community and hospital settings, indeed I still practice on a monthly basis (an honorary contract at St Gemma's Hospice in Leeds). I have a strong track record in relation to practice development - most particularly in improving peoples experiences of care - and ensuring teams are safe to practice (I have undertaken inspections for the CQC). My education has equipped me with research skills which enable me to seek evidence based solutions to clinical needs and the most effective ways of achieving effective implementation. Increasingly this means finding ways to ensure better interdisciplinary working to secure high standards of care and improved health outcomes for the population we serve.

Mark Wilkinson, Chief Officer and Accountable Officer (April 14 – July 14)

Member of Finance and Performance Committee and Patient and Public Engagement Committee

Prior to joining Barnsley CCG I was the director charged with promoting life sciences innovation in the English National Health Services to increase the uptake of cost-effective medicines and medical technologies, and to improve the strategic relationship between the life sciences sector and the NHS. I originally qualified as a public sector accountant and my

first senior NHS roles were in the finance profession. I graduated from McGill University in Canada with a Master's degree in Health Leadership.

Lesley Smith, Chief Officer and Accountable Officer (July 14 – March 15)

I have leadership experience in both the private and public sectors, including the senior civil service, where I worked as a health policy adviser to government. I am an experienced Chief Officer, having spent seven years as a Chief Executive in the NHS, both in Yorkshire and in Scotland. I also have ten years of board level experience in a variety of director roles. I have experience of commissioning, service redesign and delivery across primary care, community, mental health and acute services. An accountant by profession I spent six years as a management consultant, including three years with KPMG Consulting, working with a range of clients in the UK and abroad, on large-scale change projects and their impact in people.

I live in Leeds and am married with a son and daughter, now in their early twenties.

Chris Ruddlesdin, Lay Member Representative for Patient & Public Engagement

Chair of Patient and Public Engagement Committee; member of Audit Committee; Remuneration Committee; Quality and Patient Safety Committee; Equality Steering Group

I was born in Hoyland and went to school in Barnsley. After university, I lived in Barnsley and worked for the NHS in Barnsley until retirement in 2009. I have been a governor at Crevesford Special School, and I currently chair the Barnsley Patient Council, a forum to allow the voice of Barnsley people to be heard with regard to health-care issues. I am also a volunteer for the lock-keeper for the Canal and River Trust.

Dr Mike Simms, Secondary Care Clinician

Member of Quality and Patient Safety Committee; Remuneration Committee; and Patient and Public Engagement Committee

I am a consultant with Chesterfield Royal Hospital.

GOVERNING BODY		
Name	**Position**	**Details of interest**
Anne Arnold	Lay Member, Barnsley Clinical Commissioning Group	• No Interests to declare
Nick Balac	Chair, Barnsley Clinical Commissioning Group	• Partner at St Georges Medical Practice (PMS) • Practice holds Barnsley Clinical Commissioning Group Vasectomy contract • Member of Barnsley People's First Limited Liability Partnership • Member Royal College General Practitioners • Member of the British Medical Association • Member Medical Protection Society
Clare Bannon	GP Member, Barnsley Clinical Commissioning Group	• GP Partner at Dove Valley Practice Barnsley. With interest in and further training in minor surgery, joint injections, contraceptive implants, IUDs and dermatology. • Husband (Dr Nicholas Mallaband) is an Acute Medicine Consultant at Doncaster and Bassetlaw Acute Trust. He is also a simulation training lead for South Yorkshire and Humber CMTs.

GOVERNING BODY		
Name	**Position**	**Details of interest**
		• Member of the British Medical Association • Member of the Royal College of General Practitioners
Robert Farmer	GP Member, Barnsley Clinical Commissioning Group	• GP Partner at Walderslade Surgery, Barnsley • Member of the British Medical Association • Member of the Royal College of General Practitioners. • Wife is a salaried GP in Derbyshire
Mehrban Ghani	Medical Director, Barnsley Clinical Commissioning Group	• GP Partner at White Rose Medical Practice, Cudworth, Barnsley • Directorship at 5AAG Ltd, 15 Newham Road, Rotherham
John Harban	GP Member, Barnsley Clinical Commissioning Group	• GP Partner at Lundwood Medical Centre and The Kakoty Practice, Barnsley • Contracts with the Barnsley Clinical Commissioning Group to supply Vasectomy, Carpal Tunnels and Nerve Conduction Studies services • Owner/Director Lundwood Surgical Services • Wife is Owner/Director of Lundwood Surgical Services • Member of the Royal College of General Practitioners

GOVERNING BODY		
Name	**Position**	**Details of interest**
		• Member of the faculty of sports and exercise medicine (Edinburgh)
Anne Marie Hoyle	Practice Manager Member, Barnsley Clinical Commissioning Group	• Business Manager at The Kakoty Practice, Barnsley • Cllr Alice Cave, BMBC Elected Councillor is related • Director Barnsley Enterprise for Living Well (CIC) • Member of Yorkshire NAPC steering group • Member of the Institute of Healthcare Management
Nick Luscombe	GP Member, Barnsley Clinical Commissioning Group	• GP Partner at Huddersfield Road Partnership • Practice lead for a small dispensing branch surgery • A fierce advocate of the adoption of first world standards of medical practice into Barnsley health care • Member of the British Medical Association but not actively • Medical student and F2 tutor
Sudhagar Krishnasamy	GP Member, Barnsley Clinical Commissioning	• GP Partner at Royston Group Practice, Barnsley • Director for SKSJ Medicals Ltd

GOVERNING BODY		
Name	**Position**	**Details of interest**
	Group	• Member of the British Medical Association • Member of the Royal College of General Practitioners • GP Appraiser for NHS England • Executive member of Barnsley Local Medical Committee • Member of the Medical Defence Union
Jim Logan	Member, Barnsley Clinical Commissioning Group	• Non GP Partner at Ashville Medical Practice, Barnsley • Director of Logan Health Group, part ownership of 30% • Director CEO and 100% owner of SJM Ltd. SJM is a development company that design, build, buy and own GP practices and healthcare related buildings • Director of Chane Development part ownership of 50% • Spouse Dr Scargill is also involved with Chane Developments • Trustee of Barnsley Hospice
Vicky Peverelle	Chief of Corporate Affairs, Barnsley Clinical	• Husband was the Chief Operating Officer at BHNFT until 06/10/2014

GOVERNING BODY		
Name	**Position**	**Details of interest**
	Commissioning Group	
Brigid Reid	Chief Nurse, Barnsley Clinical Commissioning Group	• Volunteer registered Nurse, St Gemma's Hospice, 329 Harrogate Road, Moortown, Leeds LS17 6QD
Chris Ruddlesdin	Lay Member and Deputy Chair, Barnsley Clinical Commissioning Group	• No interests to declare
Mark Wilkinson	Chief Officer, Barnsley Clinical Commissioning Group (April – July 2014)	• Undertake occasional (three days per annum in own time) paid consultancy to a pharmaceutical company
Lesley Smith	Chief Officer, Barnsley Clinical Commissioning Group (July 2014 – March 2015)	• Husband is Director of Ben Johnson Ltd a York based business offering office interiors solutions, furniture, equipment and supplies for private and public sector clients. • Owner of Unlimited Potential a provider of leadership development and executive coaching to private and public sector clients, including NHS clients. • Holds Associate agreements with a number of national and local management consultancy firms providing consultancy support to the NHS. A full list can be provided. Would declare an interest and refrain from taking part in any decision involving the award of a contract to any of these firms.
Cheryl Hobson	Chief Finance Officer, Barnsley Clinical Commissioning Group (April 2014 – February	• Public Sector Director for Barnsley Community Solutions • Husband is employed by Yorkshire and Humber Commissioning Support as a client Relationship Manager

GOVERNING BODY		
Name	**Position**	**Details of interest**
	2015)	
Heather Wells	Chief Finance Officer, Barnsley Clinical Commissioning Group (February 2015 – March 2015)	• Partner holds a Senior Management position with BUPA – potential supplier of services to the NHS
Mike Simms	Secondary Care Clinician, Barnsley Clinical Commissioning Group	• No interests to declare

Signed on behalf of NHS Barnsley CCG by Lesley Smith, Accountable Officer, on 21 May 2015

6. Governance statement

6.1. Introduction and context

NHS Barnsley Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006. As at 1 April 2014, the CCG was licensed without conditions.

During 2014-15 NHS England has continued to oversee the performance and development of the CCG through its quarterly assurance process, and the CCG has been assessed as 'assured' across all domains within the framework. Nevertheless, the CCG has continued to strive to embed and enhance its governance arrangements, for example:

- All policies inherited from the predecessor PCT have now been reviewed and updated to the CCG's requirements, and made widely available to member practices and other stakeholders via the CCG's website.
- Internal reporting mechanisms have been enhanced e.g. the format of integrated performance reports to the Governing Body has been reviewed and streamlined, and the Chief Nurse now provides regular Quality Highlights Reports to the Governing Body.
- The CCG has continued to develop its already robust risk management framework. It has implemented a new, updated Governing Body Assurance Framework which has been reviewed and commended by the CCG's Internal Auditors. The CCG also participated in an independent national benchmarking exercise by the Healthcare Financial Management Association (HFMA) and KPMG. All required assurances are now reflected in Committee work plans. The Integrated Risk Management Framework has been reviewed and updated.
- A detailed Business Continuity Plan to support the CCG's Business Continuity Policy approved in December 2013 has been developed, and the CCG participated in the regional test of preparedness for an Ebola outbreak on 4 November 2014.

This is an ongoing iterative process of improvement which will continue into 2015-16 as the CCG's responsibilities change:

- In January 2015 the CCG submitted a successful application to NHS England to take on delegated responsibility for the commissioning of primary medical care services from 2015-16, a process which necessitated the Constitution and Corporate Manual to be thoroughly reviewed and updated.
- Thorough reviews of the organisational and decision making structures beneath the Governing Body and its Committees have been undertaken in the year, and appropriate changes are planned in 2015-16.
- As part of the co commissioning application the CCG has strengthened its Conflicts of Interest Policy to adhere to of the new statutory guidance issued by NHS England in

December 2014, and also agreed Terms of Reference for a new Primary Care Commissioning Committee which will operate from April 2015

- The CCG has worked closely with the local authority and other partners to develop appropriate governance arrangements for the Better Care Fund which will also come into effect from 2015-16.

The Governing Body continues to oversee the CCG's performance through the engagement of its members in the work of the CCG and the performance & risk management arrangements described in this Statement.

6.2. Scope of responsibility

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

I am responsible for ensuring that the clinical commissioning group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

6.3. Compliance with the Corporate Governance Code

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

6.4. 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.

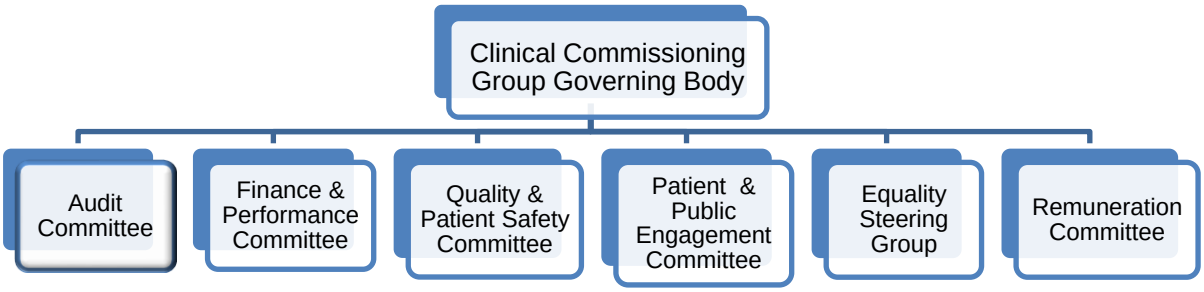
This section provides details of how this has been achieved.

6.4.1. Key features of the CCG's constitution

CCGs are member organisations. The 36 Barnsley General Practitioner (GP) Practices each nominate one representative to the **Membership Council,** which elects eight members to the Governing Body. The Membership Council has met eight times during 2014-15. The

functions reserved to the Membership Council are the agreement of the CCG's long term strategic plans, the agreement and approval of the annual commissioning intentions, and the approval of all significant service transformation plans.

The Membership Council has delegated the responsibility for carrying out the remaining functions of the CCG to the Governing Body and its Committees:



Beneath the Committee structure the CCG has six **Programme Boards** to drive service developments supporting the delivery of the CCG's commissioning priorities. The Programme Boards are each led by a clinician and a senior officer of the CCG. Each report regularly into the Finance and Performance Committee to provide assurance that projects are on track, delivering positive outcomes, and that risks are being managed.

6.4.2. Information about the Governing Body

The **Governing Body** has responsibility for leading the development of the vision and strategy, and for agreeing the Annual Commissioning Plan in collaboration with the Membership Council. It also retains overall responsibility for financial management, quality improvement, and monitoring and reporting performance against the plan. The 2014-15 Annual Report provides details of the Governing Body members including their attendance records (section 4.1.2), personal profiles, remuneration paid to senior managers and any declared interests of those managers (section 5, Remuneration Report).

6.4.3. Committees of the Governing Body

Some of the Governing Body's functions are exercised on its behalf by its Committees. Terms of Reference for all Committees are available via the CCG's website (www.barnsleyccg.nhs.uk/about-us/committees). Minutes of all Committees are reported to the Governing Body, significant matters are escalated through the risk management framework (described at section 6.5), and Governing Body members sit on the Committees. Each Committee produces and presents to the Governing Body an annual report setting out how it has discharged its responsibilities as set out in its Terms of Reference, its key achievements in the year, how it has assessed its own effectiveness, and the key risks it has

been responsible for managing. In this way the Governing Body remains fully sighted on all key risks and activities across the CCG, as described in the tables below:

Audit Committee

Function Provides assurance and advice to the Governing Body on the entirety of the CCG's control and integrated governance arrangements. This includes the proper stewardship of resources and assets, including value for money; financial reporting; the effectiveness of audit arrangements (internal and external); and risk management arrangements.		
Assurance provided to the Governing Body The Committee receives and reviews the Risk Register and Assurance Framework on a regular basis. It considers reports and opinions from internal audit, external audit, and the Local Counter Fraud Service. Reports on tender waivers, declarations of interest, gifts & hospitality are considered at every meeting. It reviews the annual accounts and annual governance statement and recommends these for approval to the Governing Body. This enables the Audit Committee to assure the Governing Body that the system of internal control set out in the constitution and corporate manual is being implemented effectively.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Governance Lay Member (Chair)	Anne Arnold	5 out of 5 (100%)
PPE Lay Member	Chris Ruddlesdin	5 out of 5 (100%)
Elected Governing Body Member	James Logan	5 out of 5 (100%)
Practice Manager Governing Body Member	Marie Hoyle	4 out of 5 (80%)
Member of the Membership Council	Dr J Maters	5 out of 5 (100%)

Finance and Performance Committee

Function Advises and supports the Governing Body in scrutinising and tracking of key financial and service priorities, outcomes and targets.		
Assurance provided to the Governing Body An Integrated Performance Report is taken to every Governing Body meeting, providing assurance that the CCG is delivering its key performance targets and statutory financial duties and providing early warning where this is not the case.		
Membership and attendance		
Role	*Name*	*Meetings attended*
The Chair of the Governing Body (Chair)	Dr Nick Balac	10 out of 11 (91%)
Governance Lay Member	Anne Arnold	10 out of 11 (91%)
Elected Governing Body Member	Dr John Harban	11 out of 11 (100%)
Elected Governing Body Member	Dr Nick Luscombe	9 out of 11 (82%)
Elected Governing Body Member	James Logan	11 out of 11 (100%)
Member of the Membership Council	Dr P Kakoty (Apr –July 2014, subsequently vacant)	1 out of 4 (25%)
The Chief Officer	Mark Wilkinson (Apr – July 2014) Lesley Smith (July 2014 – March 2015)	2 out of 4 (50%) 6 out of 7 (86%)

Role	*Name*	*Meetings attended*
The Chief Finance Officer	Cheryl Hobson (Apr 2014 – Feb 2015) Heather Wells (Feb – Mar 2015)	10 out of 10 (100%) 1 out of 1 (100%)
Chief of Corporate Affairs	Vicky Peverelle	10 out of 11 (91%)

Quality & Patient Safety Committee

Function
Advises the Governing Body with a view to ensuring that effective quality arrangements underpin all services commissioned on behalf of the CCG, regulatory requirements are met and safety is continually improved to deliver a better patient experience.
Assurance provided to the Governing Body
The Committee receives monthly Patient Safety reports covering quality, patient safety, serious incident reviews, safeguarding, infection control, mortality rates, and other relevant issues. Quality Highlights reports are provided to the Governing Body after every meeting.

Membership and attendance		
Role	*Name*	*Meetings attended*
Medical Director (Chair)	Dr Mehrban Ghani	8 out of 10 (80%)
Chief Nurse (Deputy Chair)	Brigid Reid	8 out of 10 (80%)
Governing Body Secondary Care Clinician	Mike Simms	4 out of 10 (40%)
Member of the Membership Council (clinical advisor)	Dr Mohammad Ali	4 out of 10 (40%)
Member of the Membership Council (clinical advisor)	Dr M Kadarsha	2 out of 10 (20%)
Elected Governing Body Member	Dr R Farmer	9 out of 10 (90%)
Elected Governing Body Member	Dr S Krishnasamy	8 out of 10 (80%)
PPE Lay Member	Chris Ruddlesdin	5 out of 10 (50%)
Head of Medicines Management	Chris Lawson	2 out of 10 (20%)
Deputy Chief Nurse	Karen Martin	8 out of 10 (80%)

Patient and Public Engagement Committee

Function
Provides advice to the Governing Body on communication and patient, carers and public engagement, ensuring that Patient and Public Engagement is central to the business of the CCG.
Assurance provided to the Governing Body
The Committee develops and reviews the Patient & Public Engagement Strategy and Plan, and receives regular updates on all PPE related activities across the CCG to ensure these are aligned to the commissioning priorities.

Membership and attendance		
Role	*Name*	*Meetings attended*
PPE Lay Member (Chair)	Chris Ruddlesdin	5 out of 5 (100%)
Chair of the Governing Body	Dr Nick Balac	3 out of 5 (60%)
Chief Officer	Mark Wilkinson (Apr – July 2014) Lesley Smith (July 2014 – March 2015)	2 out of 2 (100%) 1 out of 3 (33%)

Role	*Name*	*Meetings attended*
Chief Nurse	Brigid Reid	2 out of 5 (40%)
Governing Body Secondary Care Clinician	Mike Simms	0 out of 5 (0%)
Elected Governing Body Member	Dr Claire Bannon	3 out of 5 (60%)
Practice Manager Governing Body Member	Marie Hoyle	5 out of 5 (100%)
Member of the Membership Council	Dr Amjed Ali (Apr to July 2014, subsequently vacant)	0 out of 5 (0%)
Chief of Corporate Affairs	Vicky Peverelle	4 out of 5 (80%)
Communications and Engagement Lead	Kirsty Waknell	5 out of 5 (100%)

Equality Steering Group

Function
Advises the Governing Body to ensure that effective systems are in place to manage and oversee the implementation of a strategic vision for equality, diversity and human rights across all services commissioned on behalf of the CCG.

Assurance provided to the Governing Body
This group establishes and monitors the CCG's action plan related to its equality duties. The group has ensured a process for equality impact assessments is in place, supported staff briefings, and leads on the approval and review of human resources policies.

Membership and attendance

Role	*Name*	*Meetings attended*
Chief Nurse (Chair)	Brigid Reid	1 out of 3 (33%)*
PPE Lay Member	Chris Ruddlesdin	2 out of 3 (66%)
Elected Governing Body Member	Dr Claire Bannon	2 out of 3 (66%)
Member of the Membership Council	Dr Saxena	3 out of 3 (100%)
Member of the Membership Council	Vacant	N/A
Practice Manager Governing Body Member	Marie Hoyle	2 out of 3 (66%)
Deputy Chief Finance Officer (Contracting)	Patrick Otway	3 out of 3 (100%)
Head of Assurance	Richard Walker	2 out of 3 (66%)

*****due to sickness absence, the Practice Manager deputised as chair.

Remuneration Committee

Function
Advises the Governing Body on determinations about the appropriate remuneration, fees and other allowances; terms of service for employees and for people who provide services to the CCG; and provisions for other benefits and allowances under any pension scheme.

Assurance provided to the Governing Body
Drawing on benchmarking and expert HR advice, the Remuneration Committee has advised the Governing Body on appropriate remuneration and contractual arrangements for Governing Body members and others not covered by Agenda For Change terms and conditions.

Membership and attendance

Role	*Name*	*Meetings attended*
Governance Lay Member (Chair)	Anne Arnold	3 out of 6 (50%)
PPE Lay Member (Deputy Chair)	Chris Ruddlesdin	6 out of 6 (100%)
Chair of the Governing Body	Dr Nick Balac	6 out of 6 (100%)
Elected Governing Body Member	Dr John Harban	4 out of 6 (66%)
Elected Governing Body Member	Dr Nick Luscombe	5 out of 6 (83 %)

Role	*Name*	*Meetings attended*
Practice Manager Governing Body Member	Marie Hoyle	3 out of 6 (50%)
Governing Body Secondary Care Clinician	Mike Simms	2 out of 6 (33%)

6.4.4. Information about the Health and Wellbeing Board

The CCG's Chair and Chief Officer are also members of the Barnsley Health & Wellbeing Board, a Committee of Barnsley Metropolitan Borough Council which was set up in April 2013 as a requirement of section 194 of the Health and Social Care Act 2012. The objective of the Health & Wellbeing Board is to promote integrated working across health and care services and to redesign health and wellbeing services across organisational boundaries so that services are joined up and health outcomes are improved for local people.

The Health and Wellbeing Board also has very senior representatives from a range of other stakeholders including Barnsley Metropolitan Borough Council, Barnsley Hospital NHS Foundation Trust, South West Yorkshire Partnership Foundation Trust, NHS England, Barnsley Healthwatch, and South Yorkshire Police. The Board produces and regularly updates a Joint Strategic Needs Assessment, which underpins the Health and Wellbeing Strategy 2014-19 approved by the Board in April 2014. Barnsley CCG's Strategic Commissioning Plan is fully aligned with the Health & Wellbeing Strategy. In September 2014, Barnsley's Health and Wellbeing Board also approved the Better Care Fund submission.

6.4.5. Information about South Yorkshire Commissioners and Providers Forum

The role of SYCOM & Providers Forum is to enable the South Yorkshire and Bassetlaw and North Derbyshire Clinical Commissioning Groups (CCGs), the Local Area Team of NHS England, and NHS provider organisations in South Yorkshire & Bassetlaw to collaborate and take joint actions in the areas where there is a common interest, including patient pathways. SYCOM seeks to achieve enhanced patient experience, improved outcomes and more efficient service delivery through collaborating in the commissioning and provision of healthcare across primary care, public health services, non-specialised secondary care and specialised services.

The forum represents the interests of and is accountable to its members. Minutes of its meetings are reported to Barnsley CCG's Governing Body.

6.4.6. Effectiveness of the Governing Body

The Governing Body has been proactive in improving its effectiveness during the year. For example:

- An independent mid-year review commissioned by the CCG identified a range of opportunities for enhancements to the CCG's arrangements for reporting financial information and to the wider governance and decision making structures
- The preparation of the CCG's application to take on delegated responsibility for the commissioning of primary medical services was the catalyst for a review of aspects of the CCG's Governance and resulted in a strengthened approach to managing Conflicts of Interest and agreement to set up a new Primary Care Commissioning Committee from April 2015
- The Governing Body held an organisational development day in August 2014 where a number of opportunities for improving the CCG's effectiveness were discussed, including the structure and operation of the Programme Boards, and how the CCG's relationships with key stakeholders could be further developed
- Individual personal development reviews (PDRs) have been undertaken with Governing Body members by the CCG Chair.

There will be a number of changes to the membership of the Governing Body from 1 April 2015 resulting from resignations and the expiration of terms of office of some members. In accordance with the CCG's constitution a ballot was held in March 2015 to elect 4 practice representatives to the Governing Body. Representatives from the LMC, Healthwatch Barnsley, and the public observed the counting process to provide independent assurance that the process was robust. These changes will bring challenges for the Governing Body to address during 2015-16. As a first step there will be a Governing Body away day on 23 April and further organisational development activities will take place through the year.

6.5. The CCG's risk management framework

6.5.1. Overall risk and control arrangements

In accordance with its intention of achieving the highest standards of governance and accountability, since its authorisation on 1 April 2013 the CCG has worked hard to implement, embed, and enhance its risk and control arrangements. The management of risk has now become fully embedded throughout the organisation's governance systems and processes.

The Integrated Risk Management Framework was originally approved by the Governing Body in October 2012, and has subsequently been revised and updated in April 2013 and again in July 2014. The framework sets out the CCG's commitment to the management of all risk using an integrated approach covering clinical, non-clinical, and financial risk. Accountability arrangements for risk management are clearly set out and roles and responsibilities in terms of key committees and individuals are identified, as follows:

- The *Governing Body* on behalf of the Membership Council ensures that the organisation consistently follows the principles of good governance applicable to the NHS organisation.
- The *Audit Committee* oversees the risk management function and ensures that systems of internal control exist and are functioning correctly.
- The *Committees of the Governing Body* are responsible for identifying risks to the delivery of corporate objectives, and ensuring appropriate actions are in place to mitigate them (see Risk Register and Governing Body Assurance Framework below).
- The specific responsibilities of the *Chief Officer*, *Lay members, other senior officers, and all other staff of the CCG* are clearly articulated.
- The *Risk Register* provides an ongoing identification and monitoring process for operational risks, as well as strategic risks that may adversely impact on the delivery Annual Commissioning Plan, and the CCG's strategic objectives.
- The *Governing Body Assurance Framework* is a high level report which enables the Governing Body to demonstrate how it has identified and met its assurance needs focussed on the delivery of its objectives through the annual Commissioning Plan. The Assurance Framework identifies the key risks to the delivery of corporate objectives, and sets out the controls in place to mitigate those risks and the assurances (both internal and external) available to give the Governing Body confidence that the risks are being managed.

6.5.2. Identifying, rating, and managing risks

The Integrated Risk Management Framework sets out the CCG's approach to scoring risks and the risk appetite. Any risks identified in the course of the CCG's business are scored using the National Patient Safety Agency's 5 by 5 matrix, which takes account of both the likelihood and consequence of a risk occurring to come up with an overall risk rating of between 1 and 25. Risks are then included on the risk register and prioritised as follows:

RAG	Score	Risk description	Managerial Action
	1 - 3	Low risk	Can be managed locally by routine controls.
	4 - 6	Moderate risk	Managed locally with individual risk treatment plans
	8 - 12	High risk	Senior Management attention required. Detailed planning and controls

RAG	Score	Risk description	Managerial Action
	15 - 25	Extreme risk	Immediate action Chief Officer or nominated Deputy level management

A Lead Officer (Risk Owner) for each risk is identified, and the Risk Register is shared with risk owners monthly for review and revision.

The Governing Body's risk tolerance is a score of 12 or below. These risks are managed by the appropriate Chief Officer or manager and monitored at the CCG's committees. Extreme risks (scores of 15 or higher) are considered to represent a threat to the delivery of the CCG's strategic objectives. These risks are:

- Subject to immediate Chief Officer action
- Considered and reviewed at every meeting of the Governing Body, and are
- Escalated to the Assurance Framework as gaps in control against the relevant corporate objective(s).

In addition, each Committee receives and considers extracts of both the Assurance Framework and Risk Register at every meeting, containing all risks falling within its remit, and escalates significant matters to the Governing Body. The Governing Body receives reports summarising the current position with respect to extreme risks on the Assurance Framework at every meeting, and reviews the entire document on a quarterly basis.

These arrangements have continued to evolve in 2014-15. For example:

- A Governing Body development session in February 2014 agreed to focus the Assurance Framework more clearly on the strategic level risks which genuinely threaten delivery of the CCG's objectives, and to enhance the presentation of the document to make it easier to use and to distinguish it more clearly from the Risk Register
- A follow up session in August 2014 refreshed Governing Body members' understanding of the interrelationship between the Risk Register and Assurance Framework and confirmed they remained satisfied that the key risks to the organisation were appropriately reflected and that actions were being taken in respect of the risks identified.

6.5.3. How risk management is embedded in the activity of the CCG

A range of systems and processes are in place to embed risk management more broadly in the CCG's activities. These arrangements are described briefly below.

- **Operational risk registers** in the corporate style have been developed for a range of activities and projects e.g. major contracts, programme boards, better care fund, and delegated responsibility for primary medical services. These are used to identify potential risks for inclusion in the corporate Risk Register.

- There is a well-established system of **incident reporting** which ensures that incidents are managed appropriately and that learning takes place and is shared across the organisation. Reports are extracted from the system to identify issues and trends and these are fed back to the Quality and Patient Safety Committee. Investigations are carried out into all Serious Incidents and action plans devised to address the issues identified.

- The **Local Counter Fraud Specialist (LCFS)** supports the CCG in mitigating the risks associated with fraud. Working to a risk-based annual plan approved by the Audit Committee, the LCFS has undertaken a wide range of proactive work during 2014-15to promote and embed counter fraud arrangements across the CCG. This has included fraud awareness training for all staff, publicity, fraud alerts, reviews of policies and systems, ad hoc guidance, etc. The LCFS has also undertaken proactive detection exercises, and investigations into potential frauds. The LCFS presents reports to every Audit Committee, and has also prepared an Annual Report summarising his work for the year. No significant issues have been identified.

- During 2014-15 the CCG has enhanced its arrangements to ensure its **Health and Safety** responsibilities are effectively discharged. A Health and Safety Group, reporting to the Audit Committee, supported by experts from Yorkshire and Humber Commissioning Support (YHCS), and attended by staff side as well as CCG employees, has been established. The Group reviews the annual fire and health and safety risk assessments, as well as any incidents reported, and ensures appropriate actions are being taken. During 2015-16 additional first aid capacity has been identified within the CCG, guidance for staff has been developed around issues such as stress and lone working, and mandatory training in fire and health and safety has been provided for all staff.

The CCG has taken steps through the year to develop and embed arrangements by which **public stakeholders** can influence the work of the CCG and therefore be involved in managing the risks which impact on them. For example:

- Members of the public attend Governing Body meetings which have been held at various locations across the CCG geographical area

- The Our Public Engagement Network (OPEN) has been created, enabling the CCG gather views of carers, patients, and members of the public to inform key commissioning decisions
- The CCG works closely with Healthwatch Barnsley, e.g. Healthwatch has attended a quarterly assurance meeting with NHS England, attends the Equality Steering Group, and will be invited to attend the Primary Care Commissioning Committee
- Barnsley Patient Council has been established to act as an independent advisory panel. It is made up of Barnsley residents who offer the views and expectations of members of the public and local communities served toward improving, delivering and maintaining health care services for Barnsley people
- The CCG is committed to providing representatives to attend meetings of Barnsley MBC's Area Councils.

6.6. The CCG's 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.

The governance and risk management sections (6.4 and 6.5 above) have already explained how important elements of the system of internal control work. Other key components of the internal control framework include:

- An overarching governance structure set out in the Constitution, Corporate Manual, Prime Financial Policies, and suite of corporate policies
- Beneath the Constitution and Corporate Manual, the CCG has a range of corporate policies in place to support the delivery of its statutory and other functions which have been communicated to staff, made easily available via the website, and supported by training and briefings as appropriate
- Policies and procedures for managing Conflicts of Interest, including maintaining and publishing registers of interests, gifts and hospitality (see below)
- The Governing Body & Committee Structure, underpinned by clear terms of reference and work plans (see 6.4)

- The CCG's management structure, with responsibilities clearly allocated to teams and individuals
- The Risk Management framework (see 6.5)
- Robust arrangements to ensure effective financial control including budgetary control and contract monitoring
- Ongoing monitoring of the delivery of key performance targets and commissioning priorities by the Finance & Performance Committee and the Governing Body
- The Equality Steering Group oversees the CCG's compliance with the requirements of the Equality Act 2010
- The Patient and Public Engagement Committee ensures appropriate consultation and engagement takes place with stakeholders including users of health services in Barnsley
- The CCG seeks continually to develop the skills and competencies of its employees through regular performance and development reviews, the statutory and mandatory training programme, organisational development activities including regular development sessions for the Governing Body
- Objective oversight of the internal control framework by the Audit Committee, drawing on reports from internal and external auditors
- External scrutiny by NHS England through the quarterly assurance process.

6.6.1. Conflicts of interest

The CCG has robust arrangements for managing conflicts of interest. The CCG maintains a Register of Interests covering Membership Council, Governing Body Members, and all CCG staff. The Register is publicly available on the CCG's website: www.barnsleyccg.nhs.uk/about-us/governing-body. It is also considered at the public session of the Governing Body twice a year, and the interests of Governing Body members are included in the Annual Report. The Audit Committee receives and reviews the register twice a year and updates on new or changed declarations are taken to every meeting.

The CCG's Conflicts of Interest Policy requires interests to be declared within 28 days. Declarations are recorded on a form which is returned to the Chief of Corporate Affairs who enters the interest on the Register. Declarations of Interest are requested at the commencement of all meetings of the Governing Body and its Committees. At least annually (but in reality more frequently) all staff are requested to review and update their entries in the Register.

The CCG's Conflicts of Interest policy sets out the approach to managing conflicts, and training facilitated by the CCG's external auditor has been provided to Governing Body members. The policy has recently been reviewed and clarified in the light of a recent internal audit review and to address the requirements of new statutory guidance issued by NHS England in December 2014.

6.6.2. Commissioning support

The CCG buys a range of support services from **Yorkshire and Humber Commissioning Support (YHCS)**, formerly West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU). The Service Level Agreement was reviewed prior to its expiry on 30 September 2014, and subsequently extended to 31 March 2016 following a number of adjustments. The SLA is supported by detailed work plans.

The CCG has appointed a Governing Body level 'intelligent client' for each area of service who meets on a monthly basis with the CSU's named lead for their area. In addition, there is a monthly contract monitoring meeting with the CSU's Chief Operating Officer, Deputy Chief Finance Officer, and Customer Relationship Manager to discuss any issues, problems etc.

In order to provide CCGs with assurance as to the robustness of the CSU's internal control arrangements the audit firm Deloittes is engaged by the CSU to do a wide ranging audit, the results of which are summarised in a Service Auditor Report (SAR) which is made available to all CCGs. This report is also taken into account by the Head of Internal Audit in forming his overall opinion. In response to control issues identified in the 2013-14 SAR the CCG has worked with the CSU to ensure required additional controls have been reviewed and strengthened. The CCG's internal auditors have provided independent assurance over this process. The SAR for the second half of the year was received on 20 May 2015 and indicated assurance of sufficient effectiveness of controls within that 6 month report is limited to an identified number of control objectives. However reliance can be placed on other sources of assurance (including the Head of Internal Audit Opinion and the work of KPMG) over the operation of the control framework during this period.

Yorkshire and Humber CSU was not appointed to NHS England's Lead Provider Framework for commissioning support services (CSS). A transition board has been established by NHS England to oversee the transition of CSS to new arrangements during 2015-16. Yorkshire and Humber Clinical Commissioning Groups have agreed to work collaboratively to determine future CSS requirements and provide a customer voice in the transition board arrangements.

6.6.3. Information governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal

identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Barnsley CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. During 2013-14 we established an information governance management framework and supporting processes and procedures, so that the CCG was able to report full compliance at level 2 across all standards in its 2013-14 IG Toolkit submission. Notwithstanding this success, the CCG developed an improvement plan to further embed and enhance the CCG's IG arrangements during 2014-15. Key improvements have included:

- Reviewing and updating the Information Governance Policy and Management Framework
- Refreshing basic IG training for all staff, and providing additional training and support for Information Asset Owners and Administrators
- Good practice in relation to IG has been disseminated through the organisation through direct email communications, LED displays, the intranet, and through the production of an IG Handbook
- The register of the CCG's key information assets has been enhanced and expanded
- A Freedom of Information Publication Scheme has been added to the CCG's website
- An IG Security Audit has been completed and findings shared across the CCG
- IG incidents have been continually monitored and lessons learned where appropriate
- The CCG has signed up to an Information Sharing protocol to facilitate the sharing of data where appropriate with partner organisations in Barnsley and beyond
- The CCG has reviewed and refined its arrangements for storing records electronically.

Internal Audit undertook a review of the CCG's arrangements for ensuring compliance with a sample of the requirements of the IG Toolkit in early 2015 and provided a significant assurance opinion. The CCG subsequently submitted a fully compliant IG Toolkit assessment for 2014-15.

6.7. Risk assessment in relation to governance, risk management, and internal control

6.7.1. Management and mitigation of significant risks

The CCG's process for identifying, rating, and responding to risks was described in section 6.5 above. The number and severity of the risks on the Corporate Risk Register during the year is summarised in the table below:

Date	Extreme (red)	High (Amber)	Moderate (Yellow)	Low (Green)
April 2014	4	11	16	2
September 2014	6	20	14	2
March 2015	5	24	12	2

In accordance with the CCG's Integrated Risk Management Framework any risk rated as extreme (red) is deemed to exceed the Governing Body's risk tolerance, since they are considered to threaten the delivery of the CCG's strategic objectives. Such risks are escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework. The table below sets out how the CCG's extreme risks have been (and where relevant continue to be) managed or mitigated:

Risk	How managed / mitigated	How assessed	Status at March 2015
Non achievement of Health Care Associated Infection (HCAI) trajectories relating to Clostridium Difficile and MRSA bacteraemia	There are monthly reports to both Quality & Patient Safety Committee (Q&PSC) and the Governing Body regarding infection control breaches and trajectories. The CCG's main providers participate in monthly Root Cause Analysis (RCA) discussions. A quarterly meeting to discuss closure of Post Infection Reviews with both trusts has now been established by the Deputy Chief Nurse, and is being chaired by the Nurse Consultant in Public Health (BMBC). Since April 2014, work has been carried out to scope and develop the re-specification of the IPC service (from the current contract with SWYPFT IPC team).	Delivery of targets in the commissioning plan	**4x4 = 16** Incidence of CDiff below trajectory. There has been 1 incidence of MRSA however this was a not at a local provider but was a Barnsley resident.

Risk	How managed / mitigated	How assessed	Status at March 2015
NHS Constitution pledge regarding Accident and Emergency (A&E) 4 hour waits not delivered by BHNFT	BHNFT missed the A&E 4 hour target in 3 of 4 quarters during 2013-14 however following actions in 2013-14 supported by the System Resilience Group, and the introduction of a revised management structure by the Trust, performance has significantly improved in 2014-15.	Delivery of targets in the commissioning plan	**3x4 = 12** (95% target achieved in 2014-15)
The Hospital Standardised Mortality Ratio (HSMR) for Barnsley Hospital NHS Foundation Trust (BHNFT) is higher than expected.	An independent 'deep dive' review of hospital mortality was undertaken by the Advancing Quality Alliance (AQuA) in the first quarter of 2014-15. BHNFT developed an action plan in response to the report, which has been shared with the CCG. The report, action plan, and progress updates have all been shared with the Quality & Patient Safety Committee of the CCG.	Improved HSMR rates that are comparable with similar sized organisations	**3x4 = 12** (Target forecast to be achieved in 2014-15)
YAS non achievement of response and turnaround time targets – quality impacts	Quality & Patient Safety Committee has undertaken work to understand the impact on quality and patient safety of YAS' non delivery of the response time target, e.g. breach analysis, review of incident reports etc. In light of this work the quality risk was escalated from amber (high) to red (extreme). Meetings have been held with senior managers from YAS to understand the issues, and local remediation meetings have taken place to identify specific actions to improve local performance in Barnsley.	Breach analysis to assess impact of failure to achieve target	**5x5 = 25** (YAS continues to miss both response and turnaround targets)
YAS non achievement of response and turnaround time targets – performance / reputational impacts	The CCG has held a 'confirm and challenge' meeting with YAS to discuss their performance in respect of Barnsley residents. An improvement plan has been agreed with YAS. Progress is monitored through the CCG's contract monitoring procedures, and financial penalties for the ambulance handover measure have been applied in 2014.	Performance against targets	**4x5 = 20** (YAS continues to miss both response and turnaround targets)

Risk	How managed / mitigated	How assessed	Status at March 2015
BHNFT failure to deliver diagnostic test targets	Diagnostic performance is monitored as part of contract performance. The CCG provided additional funding during 2013-14 to support additional clinics and increased capacity to address the issue. The CCG's contracting team has worked with the Trust on options to increase capacity and performance, and an action plan is in place at BHNFT to increase capacity to address non - obstetric ultrasound waiting time pressures. Performance is monitored through quality and performance meetings and contract monitoring.	Performance against target	**5x3 = 15** Inconsistent performance and target continues to be missed.
Potential impact on the urgent care system in Barnsley as a result of the loss of 30 intermediate care beds from April 2015	Operational Resilience Funding from NHSE has been used to fund the spot purchase of intermediate care to strengthen intermediate care system resilience. The SRG Committee will monitor the impact as bed closures start affecting the system in early 2015. Daily sitreps and weekly teleconferences will provide intelligence.	Impact on wider healthcare system e.g. admissions to secondary care	**2x4 = 8** Beds will now be funded by the Better Care Fund.
Potential impact on quality & patient safety of incomplete D1 discharge letters	An audit of D1 discharge letters from BHNFT undertaken by the CCG's medicines management team identified many that were incomplete or incorrect. The results of the audit have been shared with BHNFT and raised with the Trust's medical director. The CCG is to request an action plan from the Trust. D1 completion is to be included within the core contract for 2015-16 with financial penalties if not met.	Audit of discharge letters	**4x4 = 16** Being addressed as part of the contract negotiations and CQUIN development discussions. Audit to be repeated during 2015-16.

As well as being escalated to the Governing Body as gaps in control against relevant objectives in the assurance framework these risks have been allocated to the appropriate Committee and Chief Officer within the governance structure, with mitigating actions being monitored by the Committee on an ongoing basis. Risk and Assurance reports to the Governing Body will enable it to monitor the effectiveness of the mitigating actions in 2015-16 for those risks which remain open.

A development session in scheduled in April 2015 for the Governing Body to identify any new or significantly changed challenges to the delivery of its objectives in 2015-16. Any new risks will be reflected in in the 2015-16 Governing Body Assurance Framework and Risk Register and appropriate mitigating actions put in place to address them.

6.7.2. Principal risks to compliance with the CCG license

There are currently no principal risks to the CCG's license as at 31 March 2015.

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

Throughout 2014-15 the Governing Body has built upon the learning process of the first year of the CCG with regard to making investment decisions. The Governing Body has exercised control via Programme Boards and Management Team for decisions on commitment of values less than £100k and reserved the right to decide on investments over this level to the Governing Body as a whole.

In order to ensure the efficient and effective use of the Barnsley £ no investments have been approved without a clear rationale as part of a business case. In addition, a strong emphasis has been placed on ensuring return on investments are considered and an in-depth mid-year financial review was undertaken to re-evaluate and reassess the desirability and affordability of investments to move forward to implementation. Alongside this further in-depth prioritisation discussions have taken place regarding future investments and expenditure plans with a strong emphasis on return.

Robust budgetary control procedures along with detailed Financial Management policies have been implemented and reviewed to ensure that all budgets committed are in line with the Commissioning Plan and ensure value for money. As part of budgetary control, the Finance and Performance Committee and Governing Body have received a monthly integrated Performance report, detailing financial performance, in the context of activity, identifying key risks and projected courses of action. The CCG contained expenditure within allocated resources, both for Programme and Running Costs and has delivered its expected surplus. This surplus will be utilised in future years to underpin the CCGs ongoing investment programme from 2015-16.

As part of their year-end procedures Internal Audit and External Audit, through the Value for Money self-assessment process will provide an opinion in regard to the CCG's use of resources.

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

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

6.9.1. Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Officer as Accountable Officer. The Governing Body, collectively and individually, ensures that robust systems of internal control and management are in place. These arrangements, and the enhancements that have been made to them during 2014-15, are described in detail at sections 6.4 to 6.8 of this Statement.

Risk management capacity has been developed across the CCG in a number of ways during the year. The statutory and mandatory training programme for 2014-15 includes numerous elements relevant to risk management, including information governance, health and safety, fire safety, safeguarding adults and children, infection control, and fraud. Incident reporting is done via an online system accessible through the CCG's intranet. Reporting arrangements have been enhanced to prompt authors to confirm that all aspects of potential risk – financial, contractual, quality, equality and diversity, information governance, human resources, and sustainability – have been appropriately considered in the preparation of committee reports and business cases.

6.9.2. Review of effectiveness

The Accountable Officer's review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. The Accountable Officer has drawn on performance information available to her. Her review is also informed by comments made by the external auditors in their management letter and other reports.

The Governing Body Assurance Framework provides the Accountable Officer with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principal objectives have been reviewed.

The Accountable Officer has been advised on the implications of the result of her review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee, and other Committees of the CCG.

In carrying out her review the Accountable Officer has relied specifically upon:

- The quarterly assurance checkpoint information submitted to NHSE, and the outcomes from quarterly assurance meetings with NHSE (see section 6.1)
- The CCG's overall governance, risk management, and internal control arrangements (see sections 6.4 to 6.6)
- Reviews undertaken by the CCG's internal auditors, 360 Assurance, on a range of significant financial and other systems, all of which have provided significant assurance
- Performance, equality, sustainability, and other information incorporated within the Annual Report and other performance information available to me
- Results of national staff and stakeholder surveys
- The statutory external audit undertaken by KPMG, who provide an opinion on the financial statements and form a conclusion on the CCG's arrangements for ensuring economy, efficiency, and effectiveness in its use of resources during 2014-15.

6.9.2.10. Actions taken to address significant gaps in control

Section 6.7 above sets out the significant control issues identified in the year and the actions taken to address them.

6.9.2.11. The Head of Internal Audit Opinion

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

*I am pleased to report that we are providing the CCG with **Significant Assurance** as there is a generally sound system of internal control, designed to meet objectives, and that controls are generally being applied consistently. This opinion is determined through our review of your Governing Board Assurance Framework (BAF) and associated processes and the work that we have undertaken throughout the year.*

6.9.3. Data quality

Quality data is essential for commissioning effective, relevant and timely care, efficient administrative processes, management and strategic planning, establishing acceptable service agreements/contracts for healthcare provision, identification of local priorities and health needs assessments, ensuring that the organisation's expenditure is accurately

calculated, providing reliable intelligence regarding local providers, and delivery of local and national priorities. Data therefore needs to be accurate, credible, reliable and secure.

The majority of the data used by the CCG for these purposes is derived from external sources, such as providers' systems and national IT systems, and much is processed by third parties. There are regular meetings of both It and Ig Leads from the CCG and its providers, and information sharing protocols and agreements are in place where appropriate.

Based on the evidence available the CCG has concluded that the data is receives is of sufficient quality to meet its purposes. An internal audit review of the quality of providers' data is planned for 2015-16.

6.9.4. Business critical models

An appropriate framework and environment is in place to provide quality assurance of business critical models.

6.9.5. Data security

As described in section 6.6.2, the CCG has submitted a satisfactory level of compliance with the IG Toolkit assessment in 2014-15. There have been no Serious Untoward Incidents relating to data security breaches during 2014-15.

6.9.6. Discharge of statutory functions

During establishment, the arrangements put in place by the CCG and documented in the constitution, corporate manual, and prime financial policies were developed with extensive expert external input, to ensure compliance with the all relevant legislation. That expert advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

Compliance with statutory functions is delivered through the CCG's management structure and monitored through the CCG's committee structure & work plans, as described at sections 6.4 to 6.8 above. These arrangements have been subject to external scrutiny through a range of processes, including the NHS England CCG Assurance Framework.

During 2014-15 the Constitution and Corporate Manual has been subject to further rigorous scrutiny and review as amendments have been made to:

- Update the CCG's governance arrangements to support its application to take on delegated responsibility for the commissioning of primary medical care services from NHS England
- Include of role descriptors for all members of the Governing Body in accordance with the CCG Regulations 2012
- Strengthen our arrangements for managing Conflicts of Interest in the light of statutory guidance issued by NHS England in December 2014, and
- Reflect changes resulting from the legislative reform order that enabled CCGs and NHS England to form joint committees from 1 October.

All of the above changes were reviewed by independent legal advisors and approved by NHS England.

6.10. Conclusion

As Accountable Officer and based on the review process outlined above, the CCG has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Governance Statement above. My review confirms that NHS Barnsley CCG has a generally sound system of risk management and internal control that supports the achievement of its policies, aims and objectives.

Signed on behalf of NHS Barnsley CCG by Lesley Smith, Accountable Officer, on 21 May 2015

7. 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 the Clinical Commissioning Group.

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Signed on behalf of NHS Barnsley CCG by Lesley Smith, Accountable Officer, on 21 May 2015

8. Accounts section

FOREWORD TO THE ACCOUNTS

BARNSLEY CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2015 have been prepared by the Barnsley Clinical Commssioning Group under section 232(3) schedule 15 of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

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STATEMENT OF COMPREHENSIVE NET EXPENDITURE FOR THE YEAR ENDED 31 March 2015

	Note	2014-15 £'000	2013-14 £'000
Total Income and Expenditure			
Employee benefits	4.1.1	**3,941**	3,091
Operating Expenses	5	**354,761**	339,693
Other operating revenue	2	**(581)**	(453)
Net operating expenditure before interest		**358,121**	342,331
Investment Revenue	8	**0**	0
Other (gains)/losses	9	**0**	0
Finance costs	10	**0**	0
Net operating expenditure for the financial year		**358,121**	342,331
Net (gain)/loss on transfers by absorption	11	**0**	0
Total Net Expenditure for the year		**358,121**	342,331
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	**3,074**	2,603
Operating Expenses	5	**2,990**	3,559
Other operating revenue	2	**(299)**	(453)
Net administration costs before interest		**5,765**	5,709
Programme Income and Expenditure			
Employee benefits	4.1.1	**867**	488
Operating Expenses	5	**351,771**	336,134
Other operating revenue	2	**(282)**	0
Net programme expenditure before interest		**352,356**	336,622

Other Comprehensive Net Expenditure		2014-15 £'000	2013-14 £'000
Impairments and reversals	22	**0**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	0
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Movements in other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Net gain/(loss) on assets held for sale		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Share of (profit)/loss of associates and joint ventures		**0**	0
Reclassification Adjustments		**0**	0
On disposal of available for sale financial assets		**0**	0
Total comprehensive net expenditure for the year		**358,121**	342,331

The accounting policies on pages 5 to 14 form part of this statement

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2015

	Note	31 March 2015 £'000	31 March 2014 £'000
Non-current assets:			
Property, plant and equipment	13	**198**	494
Intangible assets	14	**0**	0
Investment property	15	**0**	0
Trade and other receivables	17	**0**	0
Other financial assets	18	**0**	0
Total non-current assets		**198**	494
Current assets:			
Inventories	16	**0**	0
Trade and other receivables	17	**1,915**	2,101
Other financial assets	18	**0**	0
Other current assets	19	**0**	0
Cash and cash equivalents	20	**90**	199
Total current assets		**2,005**	2,300
Non-current assets held for sale	21	**0**	0
Total current assets		**2,005**	2,300
Total assets		**2,203**	2,794
Current liabilities			
Trade and other payables	23	**(19,895)**	(17,945)
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**0**	0
Total current liabilities		**(19,895)**	(17,945)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(17,692)**	(15,151)
Non-current liabilities			
Trade and other payables	23	**0**	0
Other financial liabilities	24	**0**	0
Other liabilities	25	**0**	0
Borrowings	26	**0**	0
Provisions	30	**0**	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(17,692)**	(15,151)
Financed by Taxpayers' Equity			
General fund		**(17,692)**	(15,151)
Revaluation reserve		**0**	0
Other reserves		**0**	0
Charitable Reserves		**0**	0
Total taxpayers' equity:		**(17,692)**	(15,151)

The accounting policies on pages 5 to 14 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 21 May 2015 and signed on its behalf by:

Chief Accountable Officer Date: 21 May 2015

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY
For the year ended 31 March 2015

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(15,151)**	**0**	**0**	**(15,151)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(15,151)**	**0**	**0**	**(15,151)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating expenditure for the financial year	**(358,121)**	**0**	**0**	**(358,121)**
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 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	**(358,121)**	**0**	**0**	**(358,121)**
Net funding	**355,580**	**0**	**0**	**355,580**
Balance at 31 March 2015	**(17,692)**	**0**	**0**	**(17,692)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2013-14 (Restated)				
Balance at 1 April 2013	0	0	0	0
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	879	0	0	879
Adjusted NHS Commissioning Board balance at 1 April 2013	879	0	0	879
Changes in NHS Commissioning Board taxpayers' equity for 2013-14				
Net operating costs for the financial year	(342,331)	0	0	(342,331)
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 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	(342,331)	0	0	(342,331)
Net funding	326,301	0	0	326,301
Balance at 31 March 2014	(15,151)	0	0	(15,151)

The accounting policies on pages 5 to 14 form part of this statement

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 March 2015

	Note	2014-15 £'000	2013-14 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		**(358,121)**	(342,331)
Depreciation and amortisation	5	**296**	385
Impairments and reversals	5	**0**	0
Movement due to transfer by Modified Absorption		**0**	0
Other gains (losses) on foreign exchange		**0**	0
Donated assets received credited to revenue but non-cash		**0**	0
Government granted assets received credited to revenue but non-cash		**0**	0
Interest paid		**0**	0
Release of PFI deferred credit		**0**	0
Other Gains & Losses		**0**	0
Finance Costs		**0**	0
Unwinding of Discounts		**0**	0
(Increase)/decrease in inventories		**0**	0
(Increase)/decrease in trade & other receivables	17	**186**	(2,101)
(Increase)/decrease in other current assets		**0**	0
Increase/(decrease) in trade & other payables	23	**1,950**	17,945
Increase/(decrease) in other current liabilities		**0**	0
Provisions utilised	30	**0**	0
Increase/(decrease) in provisions	30	**0**	0
Net Cash Inflow (Outflow) from Operating Activities		**(355,689)**	(326,102)
Cash Flows from Investing Activities			
Interest received		**0**	0
(Payments) for property, plant and equipment		**0**	0
(Payments) for intangible assets		**0**	0
(Payments) for investments with the Department of Health		**0**	0
(Payments) for other financial assets		**0**	0
(Payments) for financial assets (LIFT)		**0**	0
Proceeds from disposal of assets held for sale: property, plant and equipment		**0**	0
Proceeds from disposal of assets held for sale: intangible assets		**0**	0
Proceeds from disposal of investments with the Department of Health		**0**	0
Proceeds from disposal of other financial assets		**0**	0
Proceeds from disposal of financial assets (LIFT)		**0**	0
Loans made in respect of LIFT		**0**	0
Loans repaid in respect of LIFT		**0**	0
Rental revenue		**0**	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(355,689)**	(326,102)
Cash Flows from Financing Activities			
Net Funding Received		**355,580**	326,301
Other loans received		**0**	0
Other loans repaid		**0**	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**0**	0
Capital grants and other capital receipts		**0**	0
Capital receipts surrendered		**0**	0
Net Cash Inflow (Outflow) from Financing Activities		**355,580**	326,301
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(109)**	199
Cash & Cash Equivalents at the Beginning of the Financial Year		**199**	0
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		**90**	199

The accounting policies on pages 5 to 14 form part of this statement

Note 1. Accounting Policies

NHS England has directed that the financial statements of CCG's shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2014-15* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCG's, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the CCG for the purpose of giving a true and fair view has been selected. The particular policies adopted by the CCG are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1 Going Concern

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

Note 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.

Note 1.3 Acquisitions & Discontinued Operations

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

Note 1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

Note 1.5 Charitable Funds

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

Note 1.6 Pooled Budgets

Barnsley Clinical Commissioning Group (the CCG) has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 for activities relating to Children's Services. A memorandum note to the accounts provides details of the joint income and expenditure (Note 35, Page 34)
The pool is hosted by Barnsley Metropolitan Borough Council. As a commissioner of healthcare services, the CCG makes contributions to the pool, which are then used to purchase healthcare services. The CCG accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

Note 1. Accounting Policies (Continued)

Note 1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty
In the application of the CCG's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Note 1.7.1 Critical Judgements in Applying Accounting Policies
The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

Operating lease commitments - The CCG has in substance a property lease arrangement with NHS Property Services Ltd relating to the headquarters site. NHS England determined that the CCG has not obtained sustantially all the risks and rewards of ownership of this property, the lease has been classified as an operating lease and accounted for accordingly.

Note 1.7.2 Key Sources of Estimation Uncertainty
The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
Basis of estimation of key accruals - The CCG has included certain accruals within the financial statements which are estimates. The basis of the estimation of the accruals were approved by the Deputy Chief Finance Officer, the key accruals being Healthcare contracts and prescribing and were reported to the Audit Committee.

Note 1.8 Revenue
Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

Note 1.9 Employee Benefits
Note 1.9.1 Short-term Employee Benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.
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.

Note 1.9.2 Retirement Benefit Costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

Note 1.10 Other Expenses
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Note 1. Accounting Policies (Continued)

Note 1.11 Property, Plant & Equipment

Note 1.11.1 Recognition

Property, plant and equipment is capitalised if:

· It is held for use in delivering services or for administrative purposes;

· It is probable that future economic benefits will flow to, or service potential will be supplied to the clinical commissioning group;

· It is expected to be used for more than one financial year;

· The cost of the item can be measured reliably; and,

· The item has a cost of at least £5,000; or,

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

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

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

Note 1.11.2 Valuation

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

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

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

· Land and non-specialised buildings – market value for existing use; and,

· Specialised buildings – depreciated replacement cost.

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

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

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

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.

Note 1.11.3 Subsequent Expenditure

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

Note 1.12 Intangible Assets

Note 1.12.1 Recognition

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

· When it is probable that future economic benefits will flow to, or service potential be provided to, the clinical commissioning group;

· Where the cost of the asset can be measured reliably; and,

· Where the cost is at least £5,000.

Note 1. Accounting Policies (Continued)

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

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

Note 1.12.2 Measurement

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Note 1.13 Depreciation, Amortisation & Impairments

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

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

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

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

Note 1.14 Donated Assets

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

Note 1.15 Government Grants

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

Note 1. Accounting Policies (Continued)

Note 1.16 Non-current Assets Held For Sale

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

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

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

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

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

Note 1.17 Leases

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

Note 1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

Note 1.17.2 The Clinical Commissioning Group as Lessor

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

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

Note 1. Accounting Policies (Continued)

Note 1.18 Private Finance Initiative Transactions

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

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

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

Note 1.18.1 Services Received

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

Note 1.18.2 PFI Asset

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

Note 1.18.3 PFI Liability

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

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

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

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

Note 1.18.4 Lifecycle Replacement

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

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

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

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

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

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

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

Note 1. Accounting Policies (Continued)

Note 1.19 Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.20 Cash & Cash Equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

Note 1.21 Provisions
Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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

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

Note 1.22 Clinical Negligence Costs
The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

Note 1.23 Non-clinical Risk Pooling
The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

Note 1.24 Carbon Reduction Commitment Scheme
Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

Note 1. Accounting Policies (Continued)

Note 1.25 Contingencies

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

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

Note 1.26 Financial Assets

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

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

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

Note 1.26.1 Financial Assets at Fair Value Through Profit and Loss

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

Note 1.26.2 Held to Maturity Assets

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

Note 1.26.3 Available For Sale Financial Assets

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

Note 1.26.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

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

Note 1. Accounting Policies (Continued)

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

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

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

Note 1.27 Financial Liabilities

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

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

Note 1.27.1 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.

Note 1.27.2 Financial Liabilities at Fair Value Through Profit and Loss

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

Note 1.27.3 Other Financial Liabilities

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

Note 1.28 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.

Note 1.29 Foreign Currencies

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

Note 1.30 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.

Note 1. Accounting Policies (Continued)

Note 1.31 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).

Note 1.32 Subsidiaries
Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Note 1.33 Associates
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

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

Note 1.34 Joint Ventures
Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Note 1.35 Joint Operations
Joint operations are activities undertaken by the clinical commissioning group in conjunction with one or more other parties but which are not performed through a separate entity. The clinical commissioning group records its share of the income and expenditure; gains and losses; assets and liabilities; and cash flows.

Note 1.36 Research & Development
Research and development expenditure is charged in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Statement of Comprehensive Net Expenditure on a systematic basis over the period expected to benefit from the project. It should be re-valued on the basis of current cost. The amortisation is calculated on the same basis as depreciation.

Note 1.37 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2014-15, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 13: Fair Value Measurement
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year.

Note 2. Other Operating Revenue

	2014-15 Total £'000	2014-15 Admin £'000	2014-15 Programme £'000	2013-14 Total £'000
Recoveries in respect of employee benefits	**291**	**291**	**0**	395
Patient transport services	**0**	**0**	**0**	0
Prescription fees and charges	**0**	**0**	**0**	0
Dental fees and charges	**0**	**0**	**0**	0
Education, training and research	**31**	**0**	**31**	0
Charitable and other contributions to revenue expenditure: NHS	**0**	**0**	**0**	0
Charitable and other contributions to revenue expenditure: non-NHS	**0**	**0**	**0**	0
Receipt of donations for capital acquisitions: NHS Charity	**0**	**0**	**0**	0
Receipt of Government grants for capital acquisitions	**0**	**0**	**0**	0
Non-patient care services to other bodies	**80**	**8**	**72**	50
Income generation	**0**	**0**	**0**	0
Rental revenue from finance leases	**0**	**0**	**0**	0
Rental revenue from operating leases	**0**	**0**	**0**	0
Other revenue*	**179**	**0**	**179**	8
Total other operating revenue	**581**	**299**	**282**	453

* Included in Other revenue is income received from NHS England of £150k. This related to an award of funding to the CCG to enable work to be undertaken on new national developmental programmes.

Note 3. Revenue

	2014-15 Total £'000	2014-15 Admin £'000	2014-15 Programme £'000	2013-14 Total £'000
From rendering of services	**581**	**299**	**282**	453
From sale of goods	**0**	**0**	**0**	0
Total	**581**	**299**	**282**	453

Note 4. Employee benefits and staff numbers

Note 4.1.1 Employee benefits

	2014-15									2013-14		
	Total			Admin			Programme			Total		
	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits												
Salaries and wages	**3,276**	2,746	530	**2,513**	2,261	252	**763**	485	278	2,608	2,477	131
Social security costs	**231**	231	0	**193**	193	0	**38**	38	0	188	188	0
Employer Contributions to NHS Pension scheme	**352**	352	0	**286**	286	0	**66**	66	0	295	295	0
Other pension costs	**0**	0	0	**0**	0	0	**0**	0	0	0	0	0
Other post-employment benefits	**0**	0	0	**0**	0	0	**0**	0	0	0	0	0
Other employment benefits	**0**	0	0	**0**	0	0	**0**	0	0	0	0	0
Termination benefits	**82**	82	0	**82**	82	0	**0**	0	0	0	0	0
Gross employee benefits expenditure	**3,941**	**3,411**	**530**	**3,074**	**2,822**	**252**	**867**	**589**	**278**	3,091	2,960	131
Less recoveries in respect of employee benefits (note 4.1.2)	**(291)**	(291)	0	**(291)**	(291)	0	**0**	0	0	(395)	(395)	0
Total - Net admin employee benefits including capitalised co	**3,650**	**3,120**	**530**	**2,783**	**2,531**	**252**	**867**	**589**	**278**	2,696	2,565	131
Less: Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,650**	**3,120**	**530**	**2,783**	**2,531**	**252**	**867**	**589**	**278**	2,696	2,565	131

Note 4.1.2 Recoveries in respect of employee benefits

	2014-15		
	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits - Revenue			
Salaries and wages	**(247)**	(247)	0
Social security costs	**(19)**	(19)	0
Employer contributions to the NHS Pension Scheme	**(25)**	(25)	0
Other pension costs	**0**	0	0
Other post-employment benefits	**0**	0	0
Other employment benefits	**0**	0	0
Termination benefits	**0**	0	0
Total recoveries in respect of employee benefits	**(291)**	**(291)**	**0**

Note 4.2 Average number of people employed

	2014-15			2013-14
	Total Number	Permanently employed Number	Other Number	Total Number
Total number of within Barnsley Clinical Commissioning Group	**69**	**64**	**5**	52
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

Note 4.3 Staff sickness absence and ill health retirements

	2014-15 Number	2013-14 Number
Total Days Lost	**325**	228
Total Staff Years	**64**	54
Average working Days Lost	**5.1**	4.3

	2014-15 Number	2013-14 Number
Number of persons retired early on ill health grounds	**0**	0

	£'000	£'000
Total additional Pensions liabilities accrued in the year	**0**	0

Ill health retirement costs are met by the NHS Pension Scheme

Note 4.4 Exit packages agreed in the financial year

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	1	25,201	0	0	1	25,201
£50,001 to £100,000	1	56,506	0	0	1	56,506
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	2	81,707	0	0	2	81,707

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

Analysis of Other Agreed Departures

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

* As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

Note 4.5 Pension costs

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

Note 4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.
The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Note 4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

Note 4.5.3 Scheme Provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.
With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.
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 the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Note 5. Operating expenses

	2014-15 Total £'000	2014-15 Admin £'000	2014-15 Programme £'000	2013-14 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	**3,372**	**2,505**	**867**	2,610
Executive governing body members	**569**	**569**	**0**	481
Total gross employee benefits	**3,941**	**3,074**	**867**	3,091
Other costs				
Services from other CCGs and NHS England	**3,259**	**1,311**	**1,948**	3,935
Services from foundation trusts	**247,225**	**0**	**247,225**	240,232
Services from other NHS trusts	**13,769**	**53**	**13,716**	11,804
Services from other NHS bodies	**0**	**0**	**0**	67
Purchase of healthcare from non-NHS bodies	**34,337**	**0**	**34,337**	34,721
Chair and Non Executive Members	**381**	**381**	**0**	373
Supplies and services – clinical	**492**	**0**	**492**	113
Supplies and services – general	**947**	**358**	**589**	359
Consultancy services	**259**	**64**	**195**	57
Establishment	**1,433**	**453**	**980**	653
Transport	**5**	**5**	**0**	4
Premises	**878**	**131**	**747**	211
Impairments and reversals of receivables	**0**	**0**	**0**	0
Inventories written down	**0**	**0**	**0**	0
Depreciation	**296**	**22**	**274**	385
Amortisation	**0**	**0**	**0**	0
Impairments and reversals of property, plant and equipment	**0**	**0**	**0**	0
Impairments and reversals of intangible assets	**0**	**0**	**0**	0
Impairments and reversals of financial assets	**0**	**0**	**0**	0
· Assets carried at amortised cost	**0**	**0**	**0**	0
· Assets carried at cost	**0**	**0**	**0**	0
· Available for sale financial assets	**0**	**0**	**0**	0
Impairments and reversals of non-current assets held for sale	**0**	**0**	**0**	0
Impairments and reversals of investment properties	**0**	**0**	**0**	0
Audit fees	**90**	**90**	**0**	100
Other non statutory audit expenditure				
· Internal audit services	**0**	**0**	**0**	57
· Other services	**0**	**0**	**0**	9
General dental services and personal dental services	**0**	**0**	**0**	0
Prescribing costs	**46,027**	**0**	**46,027**	44,749
Pharmaceutical services	**586**	**0**	**586**	1,095
General ophthalmic services	**22**	**0**	**22**	0
GPMS/APMS and PCTMS	**4,094**	**0**	**4,094**	718
Other professional fees excl. audit	**73**	**44**	**29**	23
Grants to other public bodies	**0**	**0**	**0**	0
Clinical negligence	**0**	**0**	**0**	0
Research and development (excluding staff costs)	**0**	**0**	**0**	0
Education and training	**78**	**78**	**0**	28
Change in discount rate	**0**	**0**	**0**	0
Provisions	**0**	**0**	**0**	0
CHC Risk Pool contributions	**510**	**0**	**510**	0
Other expenditure	**0**	**0**	**0**	0
Total Other costs	**354,761**	**2,990**	**351,771**	339,693
Total Operating expenses	**358,702**	**6,064**	**352,638**	342,784

Note 6.1 Better Payment Practice Code

Measure of compliance	**2014-15 Number**	**2014-15 £000**	2013-14 Number	2013-14 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**8,167**	**42,427**	6,389	37,974
Total Non-NHS Trade Invoices paid within target	**7,985**	**42,107**	6,108	35,919
Percentage of Non-NHS Trade invoices paid within target	**97.77%**	**99.25%**	95.60%	94.59%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**2,413**	**267,132**	1,663	254,577
Total NHS Trade Invoices Paid within target	**2,381**	**266,910**	1,587	254,288
Percentage of NHS Trade Invoices paid within target	**98.67%**	**99.92%**	95.43%	99.89%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within receipt of a vaild invoice, whichever is later. The target has been set at 95% for all of the above criteria and has been achieved.

Note 6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2014-15 £'000**	2013-14 £'000
Amounts included in finance costs from claims made under this legislation	**0**	0
Compensation paid to cover debt recovery costs under this legislation	**0**	0
Total	**0**	0

Note 7. Income Generation Activities

The CCG does not undertake any income generation activities.

Note 8. Investment revenue	**2014-15 £'000**	2013-14 £'000
Rental Revenue		
PFI finance lease revenue (planned)	**0**	0
PFI finance lease revenue (contingent)	**0**	0
Other finance lease revenue	**0**	0
Total rental revenue	**0**	0
Interest Revenue		
LIFT: equity dividends receivable	**0**	0
LIFT: loan interest receivable	**0**	0
Bank interest	**0**	0
Other loans and receivables	**0**	0
Impaired financial assets	**0**	0
Other financial assets	**0**	0
Total interest revenue	**0**	0
Total investment revenue	**0**	0

Note 9. Other gains and losses

	2014-15 £'000	2013-14 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	**0**	0
Gain/(loss) on disposal of intangible assets other than by sale	**0**	0
Gain/(loss) on disposal of financial assets other than held for sale	**0**	0
Gain/(loss) on disposal of assets held for sale	**0**	0
Gain/(loss) on foreign exchange	**0**	0
Change in fair value of financial assets carried at fair value through the statement of comprehensive net expenditure	**0**	0
Change in fair value of financial liabilities carried at fair value through the statement of comprehensive net expenditure	**0**	0
Change in fair value of investment property	**0**	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	**0**	0
Total	**0**	0

Note 10. Finance costs

	2014-15 £'000	2013-14 £'000
Interest		
Interest on loans and overdrafts	**0**	0
Interest on obligations under finance leases	**0**	0
Interest on obligations under PFI contracts:		
· Main finance cost	**0**	0
· Contingent finance cost	**0**	0
Interest on obligations under LIFT contracts:		
· Main finance cost	**0**	0
· Contingent finance cost	**0**	0
Interest on late payment of commercial debt	**0**	0
Other interest expense	**0**	0
Total interest	**0**	0
Other finance costs	**0**	0
Provisions: unwinding of discount	**0**	0
Total finance costs	**0**	0

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

The CCG had no functions transferred that have given rise to a recognised gain or loss in 2014/15. (2013/14: nil)

Note 12. Operating Leases

Note 12.1 As lessee

Note 12.1.1 Payments recognised as an Expense

	2014-15				2013-14
	Land	**Buildings**	**Other**	**Total**	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000
Payments recognised as an expense					
Minimum lease payments	**0**	**759**	**2**	**761**	106
Contingent rents	**0**	**0**	**0**	**0**	0
Sub-lease payments	**0**	**0**	**0**	**0**	0
Total	**0**	**759**	**2**	**761**	106

The amount recognised in note 12.1.1 under Buildings has been paid to NHS Property Services Ltd (£170k) and Community Health Partnership Ltd (£589k). The amount paid to NHS Property Services Ltd in this financial year relates to the occupancy of Hillder House (the CCG's Headquarters - £116k) and void space for Health centres that were transferred to the Lessor on the abolition of the PCT (£54k).
The remaining balance, £589k relates to Void, bookable and Subsidary costs that the CCG have had to pay in relation to LIFT buildings held by Community Health Partnership.
The costs recognised in Other, relate to Photcopier Leases held by the CCG.

Note 12.1.2 Future minimum lease payments

				2014-15	2013-14
	Land	**Buildings**	**Other**	**Total**	Total
	£'000	**£'000**	**£'000**	**£'000**	£'000
Payable:					
No later than one year	**0**	**0**	**2**	**2**	0
Between one and five years	**0**	**0**	**4**	**4**	0
After five years	**0**	**0**	**0**	**0**	0
Total	**0**	**0**	**6**	**6**	0

Whilst the CCG's arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years, including void spaces, has not yet been agreed . Consequently note 12.1.2 does not include future minimum lease payments for the arrangements. The balance of Other future lease payments relates to Photocopier leases.

Note 12.2 As lessor

Note 12.2.1 Rental revenue

	2014-15	2013-14
	£'000	£'000
Recognised as income		
Rent	**0**	0
Contingent rents	**0**	0
Total	**0**	0

Note 12.2.2 Future minimum rental value

	2014-15	2013-14
	£'000	£'000
Receivable:		
No later than one year	**0**	0
Between one and five years	**0**	0
After five years	**0**	0
Total	**0**	0

Note 13 Property, plant and equipment

2014-15	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 as at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**642**	**237**	**879**
Addition of assets under construction and payments on account	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions purchased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions government granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Additions leased	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale and reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Transfer (to)/from other public sector body	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cumulative depreciation adjustment following revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cost or Valuation as at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**642**	**237**	**879**
Depreciation at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**267**	**118**	**385**
Reclassifications	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reclassified as held for sale and reversals	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Disposals other than by sale	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Upward revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments charged	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Reversal of impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Charged during the year	**0**	**0**	**0**	**0**	**0**	**0**	**177**	**119**	**296**
Transfer (to)/from other public sector body	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Cumulative depreciation adjustment following revaluation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Depreciation as at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**444**	**237**	**681**
Net Book Value as at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**198**	**0**	**198**
Purchased	**0**	**0**	**0**	**0**	**0**	**0**	**198**	**0**	**198**
Donated	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Government Granted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**198**	**0**	**198**
Asset financing:									
Owned	**0**	**0**	**0**	**0**	**0**	**0**	**198**	**0**	**198**
Held on finance lease	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
On-SOFP Lift contracts	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PFI residual: interests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**198**	**0**	**198**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £'000	Buildings £'000	Dwellings £'000	Assets under construction & payments on account £'000	Plant & machinery £'000	Transport equipment £'000	Information technology £'000	Furniture & fittings £'000	Total £'000
Balance at 1 April 2014	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revaluation gains	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Impairments	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Release to general fund	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Other movements	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

Note 13. Property, plant and equipment (continued)

Note 13.1 Additions to assets under construction
The CCG has no assets under construction as at 31 March 2015. (31 March 2014: nil)

Note 13.2 Donated assets
The CCG has no donated assets as at 31 March 2015. (31 March 2014: nil)

Note 13.3 Government granted assets
The CCG has no Government granted assets as at 31 March 2015. (31 March 2014: nil)

Note 13.4 Property revaluation
The CCG holds no property. For this reason no revaluation has taken place.

Note 13.5 Compensation from third parties
The CCG in 2014/15 has not received any income from third parties for assets impaired , lost or given up, that is included in the Statement of Comprehensive Net Expenditure.(31 March 2014: nil)

Note 13.6 Write downs to recoverable amount
The CCG has not written any assets down to their recoverable amounts or had any reversals of previous write downs.
(31 March 2014: nil)

Note 13.7 Temporarily idle assets
The CCG has no temporarily idle assets as at 31 March 2015. (31 March 2014: nil)

Note 13.8 Cost or valuation of fully depreciated assets
The CCG has no fully depreciated assets still in use as at 31 March 2015.(31 March 2014: nil)

Note 13.9 Economic lives
The economic lives of the non current assets held by the CCG are shown below.

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	1	3
Furniture & fittings	0	0

Note 14 Intangible non-current assets

2014-15	Computer Software: Purchased £'000	Computer Software: Internally Generated £'000	Licences & Trademarks £'000	Patents £'000	Development Expenditure (internally generated) £'000	Total £'000
Cost or Valuation as at 1 April 2014	0	0	0	0	0	**0**
Additions purchased	0	0	0	0	0	**0**
Additions internally generated	0	0	0	0	0	**0**
Additions donated	0	0	0	0	0	**0**
Additions government granted	0	0	0	0	0	**0**
Additions leased	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale and reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Upward revaluation gains	0	0	0	0	0	**0**
Impairments charged	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Transfer (to)/from other public sector body	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
Cost or Valuation as at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Amortisation at 1 April 2014	0	0	0	0	0	**0**
Reclassifications	0	0	0	0	0	**0**
Reclassified as held for sale and reversals	0	0	0	0	0	**0**
Disposals other than by sale	0	0	0	0	0	**0**
Upward revaluation gains	0	0	0	0	0	**0**
Impairments charged	0	0	0	0	0	**0**
Reversal of impairments	0	0	0	0	0	**0**
Charged during the year	0	0	0	0	0	**0**
Transfer (to) from other public sector body	0	0	0	0	0	**0**
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	**0**
Amortisation at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Net Book Value as at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**
Purchased	0	0	0	0	0	**0**
Donated	0	0	0	0	0	**0**
Government Granted	0	0	0	0	0	**0**
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

Revaluation Reserve Balance for intangible assets	Computer Software: Purchased £'000	Computer Software: Internally Generated £'000	Licences & Trademarks £'000	Patents £'000	Development Expenditure (internally generated) £'000	Total £'000
Balance at 1 April 2014	0	0	0	0	0	**0**
Revaluation gains	0	0	0	0	0	**0**
Impairments	0	0	0	0	0	**0**
Release to general fund	0	0	0	0	0	**0**
Other movements	0	0	0	0	0	**0**
Total at 31 March 2015	**0**	**0**	**0**	**0**	**0**	**0**

Note 14 Intangible non-current assets (Continued)

Note 14.1 Donated assets

The CCG has no donated assets as at 31 March 2015.(31 March 2014: nil)

Note 14.2 Government granted assets

The CCG has no Government granted assets as at 31 March 2015. (31 March 2014: nil)

Note 14.3 Revaluation

The CCG hold no tangible assets. For this reason no revaluation has taken place.

Note 14.4 Compensation from third parties

The CCG in 2014/15 has not received any income from third parties for assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure. (31 March 2014: nil)

Note 14.5 Write downs to recoverable amount

The CCG has not written any assets down to their recoverable amounts or had any reversals of previous write downs. (31 March 2014: nil)

Note 14.6 Non-capitalised assets

The CCG has no intangible assets that are not recognised as assets because they did not meet the recognition criteria. (31 March 2014: nil)

Note 14.7 Temporarily idle assets

The CCG has no temporarily idle assets as at 31 March 2015. (31 March 2014: nil)

Note 14.8 Cost or valuation of fully amortised assets

The CCG has no fully depreciated assets still in use as at 31 March 2015. (31 March 2014: nil)

Note 14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	0	0
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

Note 15 Investment property
The CCG has no Investment property as at 31 March 2015.(31 March 2014: nil)

Note 16 Inventories
The CCG has no Inventories as at 31 March 2015.(31 March 2014: nil)

Note 17 Trade and other receivables

	Current 2014-15 £'000	**Non-current 2014-15 £'000**	Current 2013-14 £'000	Non-current 2013-14 £'000
NHS receivables: Revenue	**355**	**0**	692	0
NHS receivables: Capital	**0**	**0**	0	0
NHS prepayments and accrued income	**1,356**	**0**	694	0
Non-NHS receivables: Revenue	**85**	**0**	603	0
Non-NHS receivables: Capital	**0**	**0**	0	0
Non-NHS prepayments and accrued income	**109**	**0**	96	0
Provision for the impairment of receivables	**0**	**0**	0	0
VAT	**7**	**0**	16	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**0**	**0**	0	0
Interest receivables	**0**	**0**	0	0
Finance lease receivables	**0**	**0**	0	0
Operating lease receivables	**0**	**0**	0	0
Other receivables	**3**	**0**	0	0
Total Trade & other receivables	**1,915**	**0**	2,101	0
Total current and non current	**1,915**		2,101	
Included above:				
Prepaid pensions contributions	**0**		0	

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

Note 17.1 Receivables past their due date but not impaired	**2014-15 £'000**	2013-14 £'000
By up to three months	**379**	1,198
By three to six months	**41**	97
By more than six months	**20**	0
Total	**440**	1,295

£217k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2015.

Note 17.2 Provision for impairment of receivables	**2014-15 £'000**	2013-14 £'000
Balance at 1 April 2014	**0**	0
Amounts written off during the year	**0**	0
Amounts recovered during the year	**0**	0
(Increase) decrease in receivables impaired	**0**	0
Transfer (to) from other public sector body	**0**	0
Balance at 31 March 2015	**0**	0

No receivables have been impaired by the CCG in 2014-15. (2013-14: nil)

Note 18 Other financial assets

The CCG has no Other financial assets as at 31 March 2015.(31 March 2014: nil)

Note 19 Other current assets

The CCG has no Other current assets as at 31 March 2015. (31 March 2014: nil)

Note 20 Cash and cash equivalents

	2014-15 £'000	2013-14 £'000
Balance at 1 April 2014	**199**	0
Net change in year	**(109)**	199
Balance at 31 March 2015	**90**	199
Made up of:		
Cash with the Government Banking Service	**90**	199
Cash with Commercial banks	**0**	0
Cash in hand	**0**	0
Current investments	**0**	0
Cash and cash equivalents as in statement of financial position	**90**	199
Bank overdraft: Government Banking Service	**0**	0
Bank overdraft: Commercial banks	**0**	0
Total bank overdrafts	**0**	0
Balance at 31 March 2015	**90**	199
Patients' money held by the CCG, not included above	**0**	0

Note 21 Non-current assets held for sale

The CCG has no Non-current assets held for sale as at 31 March 2015. (31 March 2014: nil)

Note 22 Analysis of impairments and reversals

The CCG has no impairments or reversals of impairments recognised in expenditure during 2014-15. (2013-14: nil)

Note 23 Trade and other payables

	Current 2014-15 £'000	**Non-current 2014-15 £'000**	Current 2013-14 £'000	Non-current 2013-14 £'000
Interest payable	**0**	**0**	0	0
NHS payables: revenue	**837**	**0**	3,862	0
NHS payables: capital	**0**	**0**	0	0
NHS accruals and deferred income	**3,734**	**0**	1,136	0
Non-NHS payables: revenue	**2,503**	**0**	3,470	0
Non-NHS payables: capital	**0**	**0**	0	0
Non-NHS accruals and deferred income	**10,139**	**0**	9,145	0
Social security costs	**38**	**0**	31	0
VAT	**0**	**0**	0	0
Tax	**44**	**0**	32	0
Payments received on account	**0**	**0**	0	0
Other payables	**2,600**	**0**	269	0
Total Trade & Other Payables	**19,895**	**0**	17,945	0
Total Current and Non-current	**19,895**		17,945	

There are no outstanding payables with the NHS pensions agency included in the table above for people due early retirements over 5 years. (31 March 2014: nil)

Other payables include £59k outstanding pension contributions at 31 March 2015 (31 March 2014: £0k)

Note 24 Other financial liabilities

The CCG has no other financial liabilities as at 31 March 2015. (31 March 2014: nil)

Note 25 Other Liabilities

The CCG has no other liabilities as at 31 March 2015.(31 March 2014: nil)

Note 26 Borrowings

The CCG has no borrowings as at 31 March 2015. (31 March 2014: nil)

Note 27 Private Finance Initiative, LIFT and other service concession arrangements

The CCG has no Private Finance Initiatives, LIFT or other service concession arrangements On or Off the Statement of Financial Position for the financial year 2014-15.

Note 28 Finance lease obligations

The CCG has no finance leases as at 31 March 2015. (31 March 2014: nil)

Note 28.1 Finance leases as lessee

The CCG has no future sublease payments expected to be received as at 31 March 2015.(31 March 2014: nil)

Note 29 Finance lease receivables

The CCG has no finance lease receivables as at 31 March 2015. (March 2014: nil)

Note 29.1 Finance leases as lessor

The CCG has no unguaranteed residual value accruing as at 31 March 2015. (31 March 2014: nil)

The CCG has no accumulated allowance for uncollectable lease receivables as at 31 March 2015. (31 March 2014: nil)

Note 29.2 Rental revenue

	2014-15 £'000	2013-14 £'000
Contingent rent	**0**	0
Other	**0**	0
Total	**0**	0

The CCG has no contingent rents recognised in expenditure during 2014-15. (2013-14: nil)

Note 30 Provisions

The CCG had no provisions as at 31 March 2015. (31 March 2014: nil) However, under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG . However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2015 is £5,568k. (31 March 2014: £8,394k)

Note 31 Contingencies

	2014-15 £'000	2013-14 £'000
Contingent liabilities		
Equal Pay	**0**	0
NHS Litigation Authority Legal Claims	**0**	0
Employment Tribunal	**0**	0
Other employee related litigation	**0**	0
Redundancy	**0**	0
Amounts recoverable against contingent liabilities	**0**	0
Net value of contingent liabilities	**0**	0
Contingent assets		
Amounts payable against contingent assets	**0**	0
Net value of contingent assets	**0**	0

Note 32 Commitments

Note 32.1 Capital commitments

The CCG has no contracted capital commitments not otherwise included in these financial statements as at 31 March 2015.(31 March 2014: nil)

Note 32.2 Other financial commitments

The CCG has no non-cancellable contracts (which were not leases, private finance initiative contracts or other service contracts or other service concession arrangements) as at 31st March 2015. (31 March 2014: nil)

Note 33 Financial instruments

Note 33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.
Because the CCG 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 CCG 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 CCG's prime financial policies and other governance documents. Treasury activity is subject to review by the CCG's internal auditors.

Note 33.1.1 Currency risk

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

Note 33.1.2 Interest rate risk

The CCG 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 CCG therefore has low exposure to interest rate fluctuations.

Note 33.1.3 Credit risk

Because the majority of the CCG's and revenue comes from parliamentary funding, The CCG 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.

Note 33.1.3 Liquidity risk

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

Note 33.2 Financial assets

	At 'fair value through profit and loss' 2014-15 £'000	Loans and Receivables 2014-15 £'000	Available for Sale 2014-15 £'000	Total 2014-15 £'000
Embedded derivatives	**0**	**0**	**0**	**0**
Receivables:				
· NHS	**0**	**355**	**0**	**355**
· Non-NHS	**0**	**85**	**0**	**85**
Cash at bank and in hand	**0**	**90**	**0**	**90**
Other financial assets	**0**	**3**	**0**	**3**
Total at 31 March 2015	**0**	**533**	**0**	**533**

Note 33 Financial instruments (continued)

Note 33.2 Financial assets (continued)

	At 'fair value through profit and loss' 2013-14 £'000	Loans and Receivables 2013-14 £'000	Available for Sale 2013-14 £'000	Total 2013-14 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	692	0	692
· Non-NHS	0	603	0	603
Cash at bank and in hand	0	199	0	199
Other financial assets	0	0	0	0
Total at 31 March 2014	0	1,494	0	1,494

Note 33.3 Financial liabilities

	At 'fair value through profit and loss' 2014-15 £'000	**Other 2014-15 £'000**	**Total 2014-15 £'000**
Embedded derivatives	**0**	**0**	**0**
Payables:			
· NHS	**0**	**4,571**	**4,571**
· Non-NHS	**0**	**15,242**	**15,242**
Private finance initiative, LIFT and finance lease obligations	**0**	**0**	**0**
Other borrowings	**0**	**0**	**0**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2015	**0**	**19,813**	**19,813**

	At 'fair value through profit and loss' 2013-14 £'000	Other 2013-14 £'000	Total 2013-14 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	4,998	4,998
· Non-NHS	0	12,615	12,615
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2014	0	17,613	17,613

Note 33.4 Maturity of financial liabilities

	Payable to DH £'000	**Payable to Other bodies £'000**	**Total £'000**
In one year or less	**0**	**19,813**	**19,813**
In more than one year but not more than two years	**0**	**0**	**0**
In more than two years but not more than five years	**0**	**0**	**0**
In more than five years	**0**	**0**	**0**
Total at 31 March 2015	**0**	**19,813**	**19,813**

Note 34 Operating segments

The CCG considers that it has only one segment in terms of Operating Segments: the commissioning of healthcare services.

	2014-15 £'000
Total Gross Expenditure (as per note 5, page 20)	**358,702**
Total Gross Income (as per note 2, page 15)	**(581)**
Total Net Expenditure as at 31 March 2015	**358,121**
Total Assets (as per Statement of financial position, page 2)	**2,203**
Total Liabilities (as per Statement of financial position, page 2)	**(19,895)**
Total Net Assets as at 31 March 2015	**(17,692)**

During the year, the CCG spent £352,638k on the commissioning of healthcare and other services, this represents 95.7% of the CCG's total available resource. 53.4% of our resources were transacted with the CCG's two main local providers: £127,904k (34.7%) to Barnsley Hospitals NHS Foundation Trust, and £69,000k (18.7%) to South West Yorkshire Partnership NHS Foundation Trust.

Note 35 Pooled budgets

The CCG has entered into a pooled budget arrangement with Barnsley Metropolitan Borough Council (BMBC), under Section 75 Health Care Act 2006. Both parties contribute funds to a pooled commissioning budget, which is hosted by BMBC. The pooled budget is managed through the Executive Commissioning Group, which allocates the funds to the Children's and Young Peoples Trust to commission integrated children's services.

Details of the pooled commissioning budget is shown below.

Contributions to pooled commissioning budget	**2014-15 £'000**	2013-14 £'000
Opening Balance at 1 April 2014	**0**	0
Barnsley Clinical Commissioning Group	**5,167**	5,211
Barnsley Metropolitan Borough Council	**26,841**	21,330
Total	**32,008**	26,541
Services commissioned from pooled budgets		
Barnsley Metropolitan Borough Council	**26,017**	21,095
South West Yorkshire Partnership NHS Foundation Trust	**5,139**	5,446
Barnsley Clinical Commissioning Group	**852**	0
Over / (Under) spend	**750**	3,618
Transfer / Use of Balances	**(750)**	(3,618)
Total	**32,008**	26,541
Net Balance	**0**	0
Balance as at 31 March 2015	**0**	0

NOTES:

The £750k shortfall in the pool has been addressed by the relevant organisations at the year end in line with IAS 31 interests in joint ventures and is based on each organisation taking their statutory obligations.

The CCG has recognised a surplus of £54k in its financial statements for 2014-15. This relates to the budgets the CCG has statutory obligations for. Barnsley Metropolitan Borough Council have recognised a charge of £804k

Note 36 NHS LIFT Investments

The CCG has no NHS LIFT Investments as at 31 March 2015. (31 March 2014: nil)

Note 37 Intra-government and other balances

	Current Receivables 2014-15 £'000	Non-current Receivables 2014-15 £'000	Current Payables 2014-15 £'000	Non-current Payables 2014-15 £'000
Balances with:				
· Other Central Government bodies	**8**	**0**	**98**	**0**
· Local Authorities	**101**	**0**	**1,925**	**0**
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	**344**	**0**	**88**	**0**
· NHS Trusts and Foundation Trusts	**1,367**	**0**	**4,483**	**0**
Total of balances with NHS bodies:	**1,711**	**0**	**4,571**	**0**
· Public corporations and trading funds	**0**	**0**	**0**	**0**
· Bodies external to Government	**95**	**0**	**13,301**	**0**
Total balances at 31 March 2015	**1,915**	**0**	**19,895**	**0**

	Current Receivables 2013-14 £'000	Non-current Receivables 2013-14 £'000	Current Payables 2013-14 £'000	Non-current Payables 2013-14 £'000
Balances with:				
· Other Central Government bodies	0	0	110	0
· Local Authorities	364	0	3,189	0
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	45	0	240	0
· NHS Trusts and Foundation Trusts	1,341	0	4,758	0
Total of balances with NHS bodies:	1,386	0	4,998	0
· Public corporations and trading funds	0	0	0	0
· Bodies external to Government	351	0	9,648	0
Total balances at 31 March 2014	2,101	0	17,945	0

Note 38 Related party transactions

The members of the Governing Body and key management staff who have had related party transactions with the CCG in 2014-15 are listed below.

		Payments to Related Party £'000	Payments from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from to Related Party £'000
St Georges Medical Centre - Dr Balac (Governing Body - Chair)	Practice Payments	125	0	0	0
White Rose Medical Practice - Dr Ghani (Governing Body - Medical Director)	Practice Payments	80	0	0	0
Lundwood Medical Centre Dr Harban (Governing Body - Member)	Practice Payments	230	0	0	0
Ashville Medical Practice - J Logan (Governing Body - Member)	Practice Payments	155	0	0	0
Dove Valley Practice - Dr Bannon (Governing Body - Member)	Practice Payments	185	0	0	0
Walderslade Surgery - Dr Farmer (Governing Body - Member)	Practice Payments	167	0	0	0
Royston Group Practice - Dr Krishnasamy (Governing Body - Member)	Practice Payments	154	0	0	0
Huddersfield Road Surgery - Dr Luscombe (Governing Body - Member)	Practice Payments	228	0	0	0
Kakoty Practice - M Hoyle (Governing Body - Member)	Practice Payments	81	0	0	0

Note 38 Related party transactions (continued)

Lesley Smith, Chief Officer for the CCG (July 2014 to present) is the owner of Unlimited Potential a consultancy firm providing leadership development and organisational development to the NHS. The CCG has made payments to this company of £127k in 2014/15. A declaration has also been made in relation to being an associate with the following companies:

- Centre for Innovation in Health Management, University of Leeds Business School.
- The Changeable Partnership Limited
- Capita Consulting
- Hygeian Consulting
- HD Insights
- Proventure
- Shepherd Taylor Partnership

No Payments have been made to these companies in 2014/15.

Cheryl Hobson, Chief Finance Officer for the CCG (April 2014 - February 2015) is a non paid Director for Barnsley Community Solutions for all of 2014/15.

Dr Mehrban Ghani, Medical Director for the CCG holds a position with SAAG Ltd. No payments have been made to this company in 2014/15

Karen Martin, Acting Chief Nurse (November 2014 to February 2015), is a joint director (co -owner) of Appletree Consultancy. No payments have been made to this company in 2014/15

Dr John Harban, Governing Body Member is a Director for Lundwood Surgical Services. No payments have been made to this company in 2014/15

Dr Sudhagar Krishnasamy,Governing Body Member is a Director for South Yorkshire Diagnostics Limited and SKSJ Medicals Limited. No payments have been made to either of these companies in 2014/15. A declaration has also been made in relation to an interest in Barnsley People's First Limited Partnership.

Jim Logan, Governing Body Member is a Director of the following companies: Logan Health Group and SJM Limited. No payments have been made to these companies in 2014/15. As well as holding two Director posts, a position as a trustee for Barnsley Hospice is also declared. The CCG made payments to Barnsley Hospice in 2014/15 totalling £1,274k for the purchase of healthcare.

Marie Hoyle, Governing Body Member, is a Director for Barnsley Enterprise for Living Well (CIC). No payments have been made to this organisation in 2014/15.

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

- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

In addition, the CCG has had a number of material transactions with other government departments and other central and local government bodies. The majority of these transactions have been with Barnsley Metropolitan Borough Council.

The CCG has received no revenue or capital payments relating to charitable funds

Note 39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the CCG for 2014/15. The following events are disclosed for the purposes of completeness and transparency, but are not considered to give rise to any material impact on the CCG's financial position at 31 March 2015.

Barnsley Better Care Fund:

In line with the national announcement of the creation of a Better Care Fund (BCF) in December 2013, the CCG has entered into a 'pooled' budget arrangement with Barnsley Metropolitan Borough Council (BMBC) with effect from 1 April 2015. The aims of the BCF are to improve outcomes for the population of Barnsley by improving integration of health and social care services. This will be underpinned by a Section 75 agreement between the commissioners. Governance arrangements are in place through the Barnsley Health and Wellbeing Board and the Board have signed-off a plan for 2015/16. The CCG will be the host of this pooled arrangement in the next financial year.

Delegated Primary Care Budgets:

In January 2015 the CCG submitted a successful application to NHS England to take on delegated responsibility for the commissioning of primary medical care services. With effect from the 1 April 2015, the CCG will assume responsibility for commissioning high quality primary care in General Practice under a delegation agreement with NHS England. The governance arrangements for commissioning will fall to the Primary Care Commissioning Committee established by the CCG in April 2015.

Note 40 Losses and special payments

Note 40.1 Losses

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

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Administrative write-offs	**0**	**0**	0	0
Fruitless payments	**0**	**0**	0	0
Store losses	**0**	**0**	0	0
Book Keeping Losses	**0**	**0**	0	0
Constructive loss	**0**	**0**	0	0
Cash losses	**0**	**0**	0	0
Claims abandoned	**0**	**0**	0	0
Total	**0**	**0**	0	0

Note 40.2 Special payments

	Total Number of Cases 2014-15 Number	**Total Value of Cases 2014-15 £'000**	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Compensation payments	**0**	**0**	0	0
Extra contractual Payments	**0**	**0**	0	0
Ex gratia payments	**0**	**0**	0	0
Extra statutory extra regulatory payments	**0**	**0**	0	0
Special severance payments	**0**	**0**	0	0
Total	**0**	**0**	0	0

Note 41 Third party assets	**2014-15 £'000**	2013-14 £'000
Third party assets held by NHS Barnsley Clinical Commissioning Group	**0**	0

Note 42 Financial performance targets

The CCG has a number of financial duties under the NHS Act 2006 (as amended).

Performance against those duties was as follows:

NHS Act Section	Duty	2014-15 Target £'000	2014-15 Performance £'000	Duty Achieved	2013-14 Target £'000	2013-14 Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income	**368,602**	**358,121**	**Yes**	352,968	342,331	Yes
223I (2)	Capital resource use does not exceed the amount specified in Directions	**0**	**0**	**Yes**	0	0	Yes
223I (3)	Revenue resource use does not exceed the amount specified in Directions	**368,602**	**358,121**	**Yes**	352,968	342,331	Yes
223J (1)	Capital resource use on specified matter(s) does not exceed the amount specified in Directions	**0**	**0**	**Yes**	0	0	Yes
223J (2)	Revenue Programme resource use on specified matter(s) does not exceed the amount specified in Directions	**361,817**	**352,356**	**Yes**	346,868	336,622	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	**6,785**	**5,765**	**Yes**	6,100	5,709	Yes

For the purposes of 223H(1); expenditure is defined as the aggregate of gross expenditure on revenue and capital in the financial year; and, income is defined as the aggregate of the notified maximum revenue resource, notified capital resource and all other amounts accounted as received in the financial year (whether under provisions of the Act or from other sources, and included here on a gross basis).

NHS Act Section 223J(2) Revenue resource use on specified matters relates to Programme resource.

Note 43 Impact of IFRS

	2014-15 £'000	2013-14 £'000
Depreciation charges	**0**	0
Interest expense	**0**	0
Impairment charge: Annually Managed Expenditure	**0**	0
Impairment charge: Departmental Expenditure Limit	**0**	0
Other Expenditure	**0**	0
Revenue receivable from subleasing	**0**	0
Total IFRS Expenditure (IFRIC 12)	**0**	0
Revenue consequences of private finance initiative/LIFT schemes under UK GAAP/ESA95 (net of any sublease revenue)	**0**	0
Net IFRS Change (IFRIC 12)	**0**	0
Capital Consequences of IFRS: private finance initiative/LIFT and other service concession arrangements under IFRIC 12		
Capital expenditure 2014-15	**0**	0
UK GAAP capital expenditure 2014-15 (reversionary interest)	**0**	0

Note 44 Analysis of charitable reserves

	2014-15 £'000	2013-14 £'000
Unrestricted funds	**0**	0
Restricted funds	**0**	0
Endowment funds	**0**	0
Total	**0**	0

9. Auditor's Report and Opinion

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS BARNSLEY CCG

We have audited the financial statements of NHS Barnsley CCG for the year ended 31 March 2015, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to the Clinical Commissioning Groups in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of NHS Barnsley CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members 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 CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

In addition we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of

any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2015 and of its net operating expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting polices directed by NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting polices directed by the NHS England with the consent of the Secretary of State as relevant to Clinical Commissioning Groups in England; and
- the information given in the Strategic Report and Members' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with NHS England's Guidance;
- any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or
- any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

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

Respective responsibilities of the CCG and auditor

The CCG is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report to you our conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

We report if significant matters have come to our attention which prevent us from concluding that the CCG has put in place 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 CCGs arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

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

We have undertaken our work in accordance with the Code of Audit Practice 2010 for local NHS bodies, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2014, as to whether the CCG has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for us to consider under the Code of Audit Practice 2010 for local NHS bodies in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

We planned and performed our work in accordance with the Code of Audit Practice 2010 for local NHS bodies. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all material respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Conclusion

On the basis of our work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2014, we are satisfied that, in all material respects, NHS Barnsley CCG put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2015.

Certificate

We certify that we have completed the audit of the accounts of NHS Barnsley CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

John Cornett, for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
St Nicholas House
31 Park Row
Nottingham
NG1 6FQ

May 2015