NHS
Barnsley Clinical Commissioning Group

Putting Barnsley People First

NHS Barnsley CCG Annual Report and Accounts

2015/16

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SECTION 1

Performance Report

Performance Report

1. Overview

1.1. Chief Officer's Overview

Welcome to our Annual Report & Accounts for the year 2015-16.

This year has been one of progress and determination.

In the refresh of our five year strategy this year, we said that we were **determined** that together we will make significant steps forward in transforming health and care services in Barnsley. This would deliver on the commitments set out in the NHS Five Year Forward View and would move us towards our long term ambition to move care closer to home.

We have seen progress in large scale programmes, bringing **fantastic benefits for patients** this year. Over 1000 people, who were at risk of being admitted to hospital within 24 hours, were assessed by the new RightCare Barnsley service as being able to receive alternative care and support, often meaning people could stay in their homes. We are hugely proud that this service has been shortlisted for a national award for the way it is improving patients' lives.

We have seen transformational ways of working gaining real momentum.

We **worked alongside patients** and providers to develop a shift in the way diabetes services will be managed and delivered. Joint delivery, by two organisations, with a single service specification and contract, will start to see real benefits for patients. The work to develop that this year has been significant and is a forerunner for integration and new models of care across Barnsley.

Barnsley people have **embraced the new iHEART Barnsley** service, introduced this year, providing extensive and speedy access to nurse and GP advice in the day and appointments in the evening and on Saturdays. The pilot service has been driven by the significant mobilisation this year of a local GP federation, committed to consistent high quality care for Barnsley people.

From April 2015 we took on the responsibility for commissioning primary medical services in general practice. This has started to provide us with greater opportunity to commission more integrated services across the whole healthcare system, something which has been a strong focus for us this year.

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 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.

On behalf of our Membership Council, Governing Body and our Chair, Dr Nick Balac, I particularly want to record our thanks to our dedicated staff in the CCG and in our member practices, partner organisations and patient groups, for their incredibly hard work and contribution over this year.

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

Lesley Smith, Chief Officer, NHS Barnsley Clinical Commissioning Group

1.2. Purpose and activities of the organisation

Our role: As a clinically-led statutory NHS body, NHS Barnsley CCG is responsible for planning and commissioning health care services for our local area to achieve the best possible health outcomes for our local population, and in doing so acting effectively, efficiently and economically. We do this by assessing local needs, agreeing priorities and strategies, and then buying services on behalf of our population from a range of providers whilst constantly responding and adapting to changing local circumstances.

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.

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.

Our strategy: Our five-year commissioning strategy *Putting the NHS Five Year View into Action* was refreshed this year and sets out our clear and credible plans for delivering our vision for health care services in partnership to meet the needs of the Barnsley population. It recognises the challenge in ensuring healthcare services are affordable and sustainable in the context of continuing demand for services and a reduction in funding for other public services. As an organisation we understand that we must deliver transformational change in order to achieve greater efficiency and effectiveness of spend on health services whilst continuously improving quality.

Our objectives are:

- To have the highest quality of governance and processes to support our business
- To commission high quality health care that meets the needs of individuals and groups
- Wherever it makes safe clinical sense to bring care closer to home
- To support safe and sustainable local hospital services, supporting them to transform the way they provide services so that they are as efficient and effective as possible for the people of Barnsley
- To develop services through real partnerships with mutual accountability and strong governance that improve health and health care and effectively use the Barnsley £. These partnerships will be with:

    - Patients
    - The public
    - Providers
    - Barnsley Metropolitan Borough Council
    - The local voluntary sector
    - And other stakeholders as required.

Achievements related to the performance of areas outlined in our strategy are highlighted in section 1.4.

Our Constitution: Through our Constitution, our 36 member practices delegate responsibility for running the organisation to our Governing Body, which in turn is supported by a range of strategic committees. Our Governing Body's role is to set the strategic direction of the organisation, seek assurance that the strategy is being delivered, and to set the culture of the organisation.

Our partnerships: We believe that we can achieve more when we work in partnership across the health and social care system, and across sectors within the system. 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.

We have set up a Clinical Transformation Board which has members from Barnsley Hospital, South West Yorkshire NHS Partnership Foundation Trust and Barnsley Council.

As a health and care community, we are already recognised as a 'Pioneer' for Integrated Services and in 2015-16 continued working together on the delivery of ongoing improvements and further integrated 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.

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

This year, as part of that work, we have been talking to people about children's surgery and anesthesia and critical care when someone has had a stroke to understand what matters most to them.

1.3. Key risks and challenges

The following issues and risks have been high on our agenda during the year 2015/16.

Urgent and emergency care: As with many areas across the country, we continue to focus on the four-hour waiting standard in accident and emergency. Recognising that this isn't just about what happens in A&E but also in the rest of the hospital and the wider health and care system, we have focused on this with all partners. Our focus as a CCG has been on driving forward both the opportunities for patients to be seen in primary care, avoiding unnecessary attendance at A&E through services like iHEART Barnsley and the role for more filtering of people as they arrive, who may need a GP rather than a member of the specialist emergency team.

Treatment times for cancer: Delivery of cancer treatment targets have been a challenge across the year with periods when the two week wait for first check-up and the 31 day standard were missed.

Access to psychological therapies (IAPT): Being able to deliver the new IAPT waiting time standards which were introduced in 2015/16 and which we will be expected to deliver against from 2016/17 has been challenging. The target is for 75% of patients to wait less than six weeks from referral to first treatment appointment with current performance being 55%.

Primary Care Co-commissioning: This year we took on the role and responsibility from NHS England for the commissioning of GP primary medical services. The way

we set up and embedded these arrangements for co-commissioning in our first year was positively rated as 'good' in the NHS England assurance framework assessment (subject to regional and national moderation) and a review by Internal Audit gave 'significant assurance' for our arrangements.

Barnsley Hospital NHS Foundation Trust (BHNFT) sustainability: Our main local acute hospital provider, Barnsley Hospital NHS Foundation Trust (BHNFT), came into the year with breaches of its licence for governance and financial situation. The work of the senior leadership team was recognised by Monitor who, in September 2015, lifted the breach of licence for governance.

They have remained in breach of licence for their financial situation. Throughout this period, we worked closely with BHNFT colleagues to understand the financial position and potential impact on the wider health and social care sector in line with both the immediate recovery plan and the longer term transformation plan. Risks associated with our financial duties are reflected on our assurance framework.

Commissioning Support: Yorkshire & Humber Commissioning Support Unit (YHCSU), from which we commissioned a range of core services in 2015/16, did not meet the threshold required for admission to a lead provider framework for the provision of end-to-end services. The ceasing of YHCSU required unplanned resource to ensure a smooth transition for the services and the people who provided them. As a result of this change, we took some services in-house and developed a number of hosting arrangements between local CCGs. We also continue to procure Information Technology (IT) and Business Intelligence (BI) services from the lead provider framework. The transition was managed effectively and hosting arrangements are governed by Memoranda of Understanding between participating CCGs.

1.4. Performance summary

1.4.1. CCG Assurance Framework

During 2015/16 NHS England has continued to oversee the performance and development of the CCG through its continuous assurance process. At the most recent checkpoint meeting the CCG was assured as 'good' for all five components (this is subject to regional and national moderation). This is a strong position and reflects the commitment and approach the CCG has taken this year.

Component	Assessment
Well-Led Organisation	Good
Delegated Functions	Good
Financial Management	Good
Performance	Good
Planning	Good

1.4.2. Our Strategic Plan commitments

We set out a number of transformation work streams in our strategic commissioning plan, which was refreshed in 2015. These were significant pieces of work which

have been delivered this year, some with further development needed, as detailed in our plan.

Work stream 1:

- Review of community nursing
- RightCare Barnsley
- Intermediate care

Work stream 2:

- Multispecialty community provider development for diabetes and respiratory services

Work stream 3:

- I HEART Barnsley (Prime Minister's Challenge Fund)
- GP Federation development

Work stream 4:

- Urgent Care Practitioners
- Risk Stratification
- IV Antibiotics
- Integrated Care Homes Team
- Voice Connects/Patient Partner
- Innovation Fund Projects
- DVT Pathways
- Cancer Pathways
- Working Together Programme
- Dementia
- Map of Medicine
- BEST
- Diagnostics in the Community
- Cancer Shared Care
- Survivorship
- Year of Care
- Tele-dermatology
- Cardiovascular Disease (CVD)

Work stream 5:

- Primary care development, sustainability and resilience

Highlighting some of the achievements throughout this year shows the commitment to improving integration, bring care closer to people's homes, reducing inequalities across the borough and driving up quality.

This year the memory assessment services merged which now sees **dementia** advisors running clinics in local GP surgeries, making it more convenient for people with dementia and their families to attend by being closer to home and often more familiar for them. It has also brought the different healthcare teams together.

The **RightCare Barnsley** service, which was mentioned in our Chief Officer's overview, has now developed to the point where it has shown how effective it is and can now be rolled out into the next phase enabling nurses to also refer patients in. Since the service started it has seen over 1000 people avoid being admitted to the acute hospital when that may have been the only or default option open to GPs. The concept and service has been shortlisted for an industry award and we are proud to see the hard work taking place in Barnsley being recognised nationally.

This year we went out to talk to people who have experience of **colorectal and prostate cancer** to help us design a different approach to care. Together with this feedback we developed a shared-care system between the hospitals and GPs. This made it possible, where appropriate, for people who had either of these two cancers to have their 3 or 6 month follow up appointments with their GP, rather than at hospital. Again, this brings the care closer to individual and focuses on them as a whole person, rather than a specific condition.

As part of our goal to reduce inequalities in health across the borough, we have invested in two significant programmes which will give more people better access to key tests. All GP practices should now be offering a blood test to assess someone's likelihood of having **deep vein thrombosis**, or DVT. Previously this test would be carried out at a hospital clinic. Because of this test now being available to GPs, people are being assessed more quickly and conveniently to them, fewer people need to go to hospital when DVT has been ruled out and it frees up capacity for those people who need to have more detailed tests and treatment in the hospital.

Similarly, investment in **spirometry** equipment for all GP practices and community nursing teams will see quicker and more convenient access to tests and ongoing monitoring for people with certain lung conditions.

An important step for us this year has been a review of the **community nursing** services across the borough. Working alongside the teams themselves and other partners, we have really challenged ourselves to ask how these services could be designed to bring the very best health outcomes for patients and be sustainable going into the future. In doing so we went out to talk to patients about what mattered to them and added that essential insight into a service specification which we will be moving towards in 2016/17.

This year we have developed a very comprehensive **mental health and wellbeing strategy.** With significant input from patients and public, the strategy for the borough now provides a clear direction for mental health commissioning.

1.4.3. Primary Care Development

The development of Primary Care is central to the delivery of sustainable out of hospital services closer to people's homes. This work stream was therefore established in order to deliver this development. The focus of the work this year has been across three key areas:

1. Workforce
2. The Practice Delivery Agreement – creating the infrastructure to increase quality and reduce inequalities of access and provision
3. The Primary Care Estate – to develop practice estate to deliver increased services

In terms of developing a workforce for the future whilst also addressing the shortage of General Practitioners the CCG has worked with its member practices in order to

progress new roles and expand the coverage of existing roles that can provide additional capacity for practices.

During the year two initiatives have been progressed. The first being the wide-scale use of Health Care Assistants in all practices to free up Nurses' time in practice and support patients with long term conditions. The CCG has done this through establishing a funded apprenticeship programme – which has just been implemented and expects to see 40 HCA's apprentices recruited to cover the 36 practices in Barnsley.

The second being to introduce a Clinical Pharmacist Role in order to offer different appointments to patients linked to their medication, and deal with minor ailments in order to alleviate pressure on GPs to deal with complex patient needs. Recruitment to these posts is underway and patients will see the benefits of this role, including more timely appointments and reviews of existing medications, in the next few months.

The Practice Delivery Agreement and local quality framework was introduced in 2014 to increase the investment in staff at practice level on a recurrent basis in order to target key activities that will really make a difference to people's health and wellbeing. This year the CCG has developed this further to increase interventions in practice to reduce heart disease, diagnose dementia earlier, increase alcohol interventions and coordinate care around patients with long term conditions.

With regards to the estate in Barnsley practices, we undertook a borough wide infrastructure survey in all practices and branch sites and have invested significantly to address the findings of the survey to improve the quality of the buildings used to deliver primary care.

This year, the CCG has also launched a new computer system whereby, with patients' permission, health care records can be shared amongst GP services and eventually other healthcare providers. The Medical Interoperability Gateway, referred to as the MIG, will give patients a much improved service when they move between different services.

1.4.4. Financial Performance

NHS Barnsley CCG achieved all of its financial duties in 2015-16. This is demonstrated in the table at section 2.2.1 and within the Annual Accounts. In addition, it is worth highlighting that the CCG ended the year with a surplus of £8.28 million, in line with NHS England expectations.

The Annual Accounts have been prepared under International Financial Reporting Standards (IFRS) and in accordance with the Annual Reporting Guidance issued by NHS England and the Department of Health Manual for Accounts.

The financial landscape for 2016-17 and beyond is challenging. CCG average growth allocations for 2016-17 were 3.4%, but Barnsley received only 2.1% as a result of funding being above national target levels. This has worsened the impact of national pressures on the CCG budget. These pressures include committed programme allocations, national tariff uplift and provider deficits which mean that the

CCG will have to dedicate more of our resources to sustaining the system, rather than transforming current health and care.

1.4.5. Provider Performance

Our Governing Body receives a monthly report on all provider performance measures. These reports are available on our website www.barnsleyccg.nhs.uk.

Challenges in-year, in common with other areas of the country, have included the A&E 4-hour wait and ambulance response times for the most critical calls. Locally we have seen challenges in consistently achieving the target to be seen with 62 days following urgent referral for cancer treatments and waiting times for access to psychological therapies.

We continue to believe that 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 2015/16, performance against the majority of the NHS 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 provider performance has been in line with the target/standard.

Referral To Treatment waiting times for non-urgent consultant-led treatment	
Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral – target 92%	Achieved
Diagnostic test waiting times	
Patients waiting for a diagnostic test should have been waiting less than six weeks from referral – target 99%	Achieved
A&E waits	
Patients should be admitted, transferred or discharged within four hours of their arrival at an A&E department – target 95% (actual 92.72% at end of February 2016)	Not Achieved
Cancer waits – 2 week wait	
Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP – target 93%	Achieved
Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected) –	Achieved

target 93%	
Cancer waits – 31 days	
Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers – target 96%	Achieved
Maximum 31-day wait for subsequent treatment where that treatment is surgery – target 94%	Achieved
Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen – target 98%	Achieved
Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy – target 94%	Achieved
Cancer waits – 62 days	
Maximum two-month (62-day) wait from urgent GP referral to first definitive treatment for cancer – target 85%	Achieved
Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers – target 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 – target 75% (standard to be met for both Red 1 and Red 2 calls separately) Red 1 Yorkshire & Humber region overall – 70.94% and Red 1 Barnsley only – 70.72%. Red 2 Yorkshire & Humber region overall – 71.58% and Red 2 Barnsley – 70.08%.	Not Achieved
Category A calls resulting in an ambulance arriving at the scene within 19 minutes – target 95%	Achieved
Mental Health waiting times	
Patients referred for Improving Access to Psychological Therapies (IAPT) services should receive their first treatment appointment within 6 weeks – target 75% (actual performance as at the end of March 2016 60.05%)	Not Achieved
Patients referred for Improving Access to Psychological Therapies **(**IAPT) services should receive their first treatment appointment within 18 weeks – target 95%	Achieved

Further details of how these targets are being addressed are outlined in section 2.2.2.

2. Performance analysis

2.1. How we measure performance

The table below details our approach to measuring performance.

NHS England's CCG Assurance Framework	We monitor our performance against the domains within the NHS England CCG Assurance Framework on an ongoing basis, and our Management Team meets with NHS England on a regular basis in "Checkpoint" meetings to formally take stock of our performance against the domains. The outcomes from these meetings are formally reported to our Governing Body via our Chief Officer Report.
Transformational programmes and delivery plans	We monitor progress on the four work streams through a range of ways, all ultimately feeding back in to the Clinical Transformation Board.
Financial performance	Our Finance and Contracting Team monitors our financial performance on an ongoing basis. Our financial performance is overseen at the Finance and Performance Committee and is reported to our Governing Body on a monthly basis in the Integrated Performance Report.
Provider performance including NHS Constitution standards	We measure the performance of providers using contractually agreed schedules of key performance indicators and quality indicators. The quality and completeness of the data received is continually assessed by our Business Intelligence team. Where performance is below the required standard for a single, or for multiple measures, the provider is asked for an explanation including actions and timeframes to bring the performance or quality of care back up to the required standard. Performance is reported and monitored monthly to the Finance and Performance Committee and to the Governing Body via the monthly Integrated Performance report. Exceptions are highlighted in the coversheet to the report. The Committee is supported in the role by the Contract Management Executive, the forum in which senior managers from the CCG and its main providers discuss and monitor contract issues.
Better Care Fund	The Better Care Fund (BCF) is intended to transform local health and social care services so that they work together to provide improved and joined up care and support. It is a government initiative, bringing existing resources from the NHS and local authorities into a single pooled budget. Performance against the pooled budget is monitored with local authority colleagues, through a sub-committee of the Health and Wellbeing Board. The CCG's Finance and Performance Committee receives reports on operational and financial performance of the BCF. The

	schemes supported by the BCF are an inherent part of the overall Integrated Performance Report to Governing Body.

2.2. Development and performance in-year

2.2.1. Financial Performance

CCGs have a number of financial duties under the National Health Service Act 2006 (as amended). Full details of the CCG's financial performance are available in the Annual Accounts section of this report. The CCG's performance against those duties in 2015/16 was as follows:

Duty	**Target** £'000s	**Actual Performance** £'000s	**Achievement**
Expenditure not to exceed income	413,328	405,048	Achieved
Capital resource use does not exceed the amount specified in Directions	0	0	Achieved
Revenue resource use does not exceed the amount specified in NHS Directions	413,328	405,048	Achieved
Capital resource use on specified matter(s) does not exceed the amount specified in NHS Directions	0	0	Achieved
Revenue resource use on specified matter(s) does not exceed the amount specified in NHS Directions – **programme**	407,432	399,761	Achieved
Revenue administration resource use does not exceed the amount specified in Directions – **running costs**	5,896	5,287	Achieved

2.2.2. Provider Performance

This section provides an overview of the key performance issues of the main NHS healthcare providers for Barnsley patients.

2.2.2.1. Barnsley Hospital NHS Foundation Trust

Barnsley Hospital NHS Foundation Trust (BHNFT) key performance issues for this year have been as follows.

Overall 18 week waiting times targets for referral to treatment (RTT) have been achieved during 2015/16 and waiting times for diagnostic tests has continued to improve with over 99% of tests undertaken within 6 weeks.

Delivery of the A& E four hour waiting times standard has however been a challenge throughout the year due to increases in the number of people attending A&E and the number of emergency admissions to hospital which have both increased from 2014/15. This has resulted in the 95% target for patients to be admitted, transferred or discharged within four hours of their arrival at an A&E department not being achieved in nine months of 2015/16. Performance for the year shows that 92.24% of patients were seen within four hours. The CCG has supported a number of initiatives during the year to reduce the number of attendances, improve the flow of patients through the hospital and improve discharge from hospital and will continue to do so into 2016/17. As a result of the pressures within A&E, ambulance handover times have also increased in 2015/16 particularly over the winter period.

Achieving the waiting times targets for cancer treatment has also been a challenge during the year. Waiting times from referral to treatment within 62 days of an urgent referral were below the target between May and July 2015, however actions taken by the hospital to improve processes and access to diagnostic testing have ensured that performance has been above the 85% target from August onwards and over 85% of patients overall during 2015/16 were treated within 62 days at Barnsley Hospital.

2.2.2.2. South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) provides community and mental health services in Barnsley.

Performance of mental health services has generally been good. Access to psychiatric liaison services are in place ensuring early support for patients attending the acute trust. Over 95% of patients are screened or triaged by psychiatric liaison service in less than four hours. Mental health services have also made good progress in preparing for the implementation of new standards for early intervention in psychosis and have been fully assured by NHS England.

In 2015/16 there were new waiting time standards introduced for psychological services (Improving Access to Psychological Services – IAPT). The first being that 75% of those referred for treatment should have their first treatment within 6 weeks and the second that 95% of those referred receive their first treatment in 18 weeks. Over 99% of those referred have received their first treatment within 18 weeks during 2015/16 however the 6 week target has been more challenging due to increasing numbers of referrals, numbers of patients not attending appointments and some workforce issues so whilst performance at the beginning of the year was good with 75.5% receiving their first treatment appointment in April, this has dropped down to less than 60% by the end of the year. The CCG and the provider are working with

NHS England IAPT Intensive Support Team to review the current services and develop an improvement plan to ensure there is improvement in 2016/17.

Community services are also performing well and targets in relation to diagnostic testing and referral to treatment times have all been met consistently during 2015/16. SWYPFT have also worked with the CCG during 2015/16 to continue to pilot a new model of intermediate care and to review community nursing services to ensure that services continue to meet the needs of patients and the growing demand on community services to support patients out of hospital.

2.2.2.3 Yorkshire Ambulance Service

Yorkshire Ambulance Service (YAS) has not met the required eight minute response target in 2015/16 for either Red 1 or Red 2 calls with annual performance being 70.94% and 71.58%.

These figures relate to its performance across the whole of the Yorkshire and Humber region it serves.

Response times for Barnsley patients, for both Red 1 and Red 2, were also below the target in 2015/16 with 70.72% and 70.08% of calls responded to within eight minutes.

NHS Wakefield CCG is the collaborative contract lead for the YAS emergency response contract across our region. Together with them, we continue to work with YAS to ensure that the service commissioned is in line with the requirements of the NHS Constitution.

2.2.3. Better Care Fund Performance

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions.

The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

The total value of the fund in 2015/16 is £20,374k. £2,016k of this is provided from grants made directly to the local authority for disabilities facilities and social care adaptations. The remaining £18,358k is provided from the CCG baseline allocation.

Note 35 of the financial statements details the contributions and services commissioned as per the pooled budget arrangement.

2.2.4. Performance against statutory duties

In addition, we work to ensure that we comply with the statutory duties laid down in the *National Health Service Act 2006 (as amended).* In particular in this section we have reflected on our duties under:

- Section 14R: Duty as to improvement in quality of services
- Section 14T: Duties as to reducing inequalities
- Section 14Z2: Public involvement and consultation by CCGs

- Section 14Z15: Contribution to the delivery of joint health and wellbeing strategies

2.2.4.1. Improvement in quality of services

The NHS Constitution places a requirement on all providers of healthcare to strive to deliver high quality and safe care to patients. Commissioners of healthcare have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations that they commission.

2.2.4.1.1. Clinical Quality Boards

This year it was recognised that there was a need for the health community to evolve strong relationships and high level communications at a senior level between providers and commissioners. Clinical Quality Boards (CQB) were therefore established in late 2015 with each main NHS provider. The Clinical Quality Boards focus on the three domains of quality: patient experience, patient safety and clinical effectiveness. We will continue to develop the work of the CQB and review progress and impact at the end of the first year with a view to strengthening.

2.2.4.1.2. Quality Assurance Visits

The purpose of the clinically led visits is to assist gaining assurance about the quality and safety of healthcare services the CCG commissions. It provides an opportunity for commissioners to engage directly with patients, clinicians and management to hear what they feel works well, their ideas for improvement and for the CCG to recommend any areas for further development. The visits are developmental in nature with a supportive and enabling focus.

Feedback will be aimed at highlighting good practice and identifying ways in which safety, experience and effectiveness can be improved. This can be through actions by the Trust and also through collaboration with other partners.

Visits have included General Surgery, Emergency Department, Theatres and 136 Suite (Mental Health).

2.2.4.1.3. Benchmarking against national reports

There is a high level of ambition for quality in Barnsley and we regularly review national reports with our providers to do a ‘true for us’ review in order to identify improvement opportunities.

Examples of this would be the Kirkup report of the Morecambe Bay investigation and the very recent Mazars report and review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust. Areas of existing positive practice are commended; gaps and areas for learning are identified. We work in partnership with our providers to pursue these improvements and provide assurance to the Governing Body.

2.2.4.1.4. Persistent Pursuit of Medicine Reconciliation

The area of improving compliance with standards for discharge summaries, which includes medicines reconciliation within the first 24 hours of admission, continues to be an area of focus for the CCG. The quality team in conjunction with the medicines management team continue to drive these improvements with the providers. Constructive solutions have been shared and further audit will provide more robust evidence of improvement throughout 2016.

2.2.4.1.5. Care Quality Commission (CQC) Inspections in Primary Care

CQC have now completed the majority of inspections in Primary Care. Quality Patient Safety Committee (QPSC) has received headline assurance re the outcomes of the inspections and the picture overall is of 'green good' outcomes for patients. There have been minor exceptions of practices which were 'inadequate', positively two practices improved out of this rating with now only one practice as inadequate. The CCG is providing significant support and signposts to support specifically to these practices.

2.2.4.1.6. CQC Inspections – BHNFT and SWYPFT

Both of the main NHS providers have been inspected by CQC in the 2015/16 financial year. The CCG was actively involved in the submission of evidence to CQC as part of the inspection process. Both providers also kept the CCG proactively informed of the progress and outcomes of the CQC visits. The CCG participated in the Quality Summit for BHNFT and have received assurance regarding the BHNFT action plan to their rating. This will be closely monitored via the CQB meetings.

2.2.4.1.7. Serious Incidents

The CCG has a responsibility for providers to ensure they have effective systems in place to identify and manage serious incidents. The CCG is informed of all serious incidents and near misses within any of its commissioned services, the key providers are BHNFT and SWYPFT. The CCG receive regular updates from these two providers regarding serious incidents and provider assurance documents to demonstrate there is a continued focus regarding lessons learned which are shared with the Quality Patient Safety Committee. Clinical Quality Boards have been introduced with each provider during 2015/16. The purpose of these meetings is to provide high level communication at a senior level between provider and commissioner.

Where it is felt that quality of care is being compromised, this is escalated to the CCG's Governing Body and through our quality assurance mechanisms.

Serious incidents involving independent contractors whose services we commission are also reported to the CCG. Yorkshire Ambulance Service report all serious incidents that involve Barnsley patients. During November 2015 the CCG ran a serious incident workshop with Care Home Managers in order to progress the reporting of serious incidents to the CCG. Since this workshop there have been two serious incidents reported and investigated.

2.2.4.1.8. Patient Experience

Barnsley Intelligence Sharing meetings allow the CCG to effectively triangulate the available intelligence across Barnsley to ensure there is a comprehensive overview of the quality and safety of services that the CCG commission.

This forum provides an opportunity to share information about healthcare providers between BCCG, the Communications department and the local Healthwatch, which is an independent consumer champion created to gather and represent the views of the public.

Friends and family test (FFT) scores and patient opinions from the NHSE Choices website are assessed in order to understand health services from a patient experience. Yorkshire Ambulance Service and Primary Care services have recently been included in the collection of FFT data. Themes and trends are analysed and taken into account alongside regional and national comparisons.

2.2.4.1.9. First Port Of Call

The First Port Of Call work recognises the value of reception staff and their influence on patient experience. It is developed using person centred interactive principles. The First Port Of Call training which was initially held in October 2015 and November 2015 had a positive evaluation with regard to the two GP Practices where it has been piloted. The First Port Of Call training will be ongoing and will be rolled out over the next 6 months.

2.2.4.1.10. 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 DIAL.

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. We have considered the national report by the Parliamentary Health Service Ombudsman in relation to complaints handling. We are satisfied that our current policy is fit for purpose and we continue to review and improve as required.

2.2.4.1.11. Safeguarding - Adults

As commissioners of care and partners in the Barnsley Safeguarding Adults Board the CCG has a key role in the safeguarding of adults. We meet with the CQC and the local authority on a monthly basis to share intelligence in particular to apply a pro-active approach to the prevention of abuse and neglect.

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. Care Homes continue to feature heavily in Adult Safeguarding concerns. We have structured and proportionate approaches to identify and address concerns within care homes.

Also, in December 2015 one care home closed following cancellation of registration by the CQC, residents and families were successfully supported by BMBC to find appropriate alternative accommodation.

The CCG Designated Nurses for safeguarding have established a quarterly meeting for the safeguarding leads in General Practice. Terms of Reference have been agreed, the main function of the meeting is to disseminate good safeguarding practice and provide an opportunity for learning.

Work has been undertaken to review and update the CCG's Safeguarding Vulnerable Clients Policy in light of new legislation. The designated nurses for safeguarding completed a self-assessment assurance tool as requested by NHSE. Although formal feedback is still awaited initial feedback from NHSE Scrutiny was positive with no areas of concern.

The CCG has also completed a self-assessment tool to assure the Safeguarding Adults Board (SAB) that the CCG is compliant with the Care Act 2014 in relation to safeguarding.

This year has seen the CCG having positive influence in the way the SAB fulfils its statutory duties under the Care Act. In July 2015 the CCG facilitated a focused development day for SAB members. This culminated in a radical review on the Boards priorities and inception of two new sub groups. In March 2015 a 360 audit was undertaken in relation to adult safeguarding, all actions identified from the audit are now complete and assurance submitted to the CCG’s audit committee.

2.2.4.1.12. Safeguarding – Children

The CCG designated nurse continues to be integral to the multi-agency Serious Case reviews and Learning Events. Outcomes and lessons learned are reported to the CCG QPSC.

The improvement notice issued in 2012 by Ofsted was lifted in 2014. The issues raised continue to be monitored by the Safeguarding Children Board, with no concerns.

The Child Sexual Exploitation Multi Agency Safeguarding Hub pilot commenced at the beginning of December 2015. This is expected to result in improved multi-agency information sharing and decision making which will facilitate better outcomes for young people.

2.2.4.2. Reducing inequalities

We looked at our strong relationship with the local authority and recognised that this year we had a chance to really progress our strategic approach to address health inequalities.

We introduced a key leadership role this year by appointing a public health consultant jointly with our local authority. This role has enhanced the quality and focus of our discussions and built on the already strong relationship we have with the local authority. We have developed a vibrant health intelligence resource from colleagues from across health and the local authority to develop a refreshed joint strategic needs assessment. This resource has also allowed us to be much more systematic about the way we collect and use data and evidence, improving the quality of our planning process.

Analysis of the opportunities for health gain in Barnsley, identified from the 2015 Right Care Atlas of Variation of Health Care and the 2014 and 2015 Commissioning for Value Packs has shifted the way we think, helping us to identify those areas where there are potential improvement opportunities and areas of need.

Working in collaboration with local partners is vital. Developing the 'Shared Ambitions for Reducing Health Inequalities', in collaboration with the local authority this year has been integral to us as a CCG.

Our medical director featured in this year's NHS Clinical Commissioner's publication, 'Delivering a healthier future: How CCGs are leading the way on prevention and early diagnosis.' The report showcases a range of innovative case studies from across the country, which demonstrates the difference that clinically led commissioning is making, with Barnsley CCG being highlighted for its role in tackling inequalities in stroke prevention.

This year, we took the decision to strengthen arrangements for reducing heath inequalities, through our Health Inequalities Targeted Scheme (HITS) in our GP practice delivery agreement, focussing on; dementia, alcohol and cardiovascular disease in phase one. We have co-designed these interventions with public health colleagues and GP member practices, to increase quality and reduce inequalities in primary care.

2.2.4.3. Public involvement and consultation

In order to effectively commission the right services on behalf of our local community, we need to find out the views and experiences of members of the public, patients, and their carers, especially those people who are less likely to speak up for themselves.

As the people who use and pay for the local NHS, it is really important for us to hear comments, experiences, ideas and suggestions from local people from across Barnsley about the ways in which we can develop and improve services to benefit our local communities.

Clinical Commissioning Groups (CCG's) who engage with their local community and build the feedback and views they gain from this into their commissioning decisions will be better placed to offer services that respond to the needs of local people and are accountable.

We encourage people who want to work with us in the development of new and existing services to join our public membership database – OPEN (Our Public Engagement Network)**.**

There are other ways for people to get involved in local health services and sharing their views and these include the following:

- Local GP Practice Patient Reference Groups (PRGs)

- Barnsley Patient Council – The Patient Council is made up of Barnsley residents who are also members of OPEN and/or their local GP Patient Reference Group. The purpose of the Patient Council is to ensure that the people, communities and populations served by the CCG have a voice which is heard in the development and delivery of services. The members work with the CCG to improve health care services and to ensure high quality and sustainable health care by putting the people of Barnsley first.

- CCG Patient and Public Engagement Committee - this is our internal assurance committee which meets bi-monthly as a sub-committee of our Governing Body.

- Healthwatch Barnsley - Healthwatch is the independent health and care champion created to gather and represent the views of the public in relation to health and social care.

As a CCG, we continue to build upon the strong foundations of the existing partnerships and relationships in place across Barnsley with both our statutory partners working across health and social care and our local community and voluntary sector organisations.

Throughout 2015/16 key highlights of our engagement work includes the following;

- Engaging with local people regarding our commissioning plans

We arranged a workshop to introduce and discuss the work that we are carrying out to take forward our commissioning plans within Barnsley over the next year and beyond.

Over fifty participants joined us for this workshop and we received some really constructive feedback and challenge on the day to take forwards and help shape our future plans. A full report detailing feedback from this can be accessed via our website at www.barnsleyccg.nhs.uk

- Developing a mental health and wellbeing commissioning strategy for Barnsley

During 2015/16 we have been working alongside our key partners within health and social care in Barnsley to lead the development of an all age (i.e. children, working age adults and the elderly – excluding dementia services) local Mental Health and Wellbeing Commissioning Strategy to cover the next five years.

We undertook two dedicated phases of engagement carried out between July and November. Feedback from both phases of engagement from both service users and carers and mental health professionals helped shape the direction and content of the final version of the strategy.
A report detailing how and where the strategy has been influenced by the feedback gathered has been compiled, circulated to all of those people who provided their feedback as part of the dedicated engagement process and can be accessed publicly via the CCG website.

- Improving access to Primary Care Services – I HEART Barnsley (Improving Health, Equality, Access, Responsiveness and Treatment)

Through building and strengthening existing GP services, the aim of the I HEART service is to enable local people across the borough to have access to a range of primary care services from 8am – 10pm on Monday to Friday and for three hours on a Saturday morning.

As part of the development of this pilot project, we engaged with local patients and the public alongside local partner organisations in order to highlight the principles of our proposed service model, ask for views and feedback on these proposals and explore what would support patients in accessing this type of service and how to communicate these changes to local residents.

During a five week period of engagement we received 165 survey responses, carried out three drop in sessions across the borough, and engaged via social media in addition to holding a patient workshop (attracting 35 attendees) which provided people with the opportunity to hear about the proposals and have their say as part of the engagement that we undertook locally. We sought views and feedback regarding our proposed service model and also obtained additional feedback for consideration to help us to determine the location of the two improved access hubs from the local surgeries who applied for consideration.

- Strengthening role GP Patient Reference Groups in Barnsley

We have been working with our GP member practices to support increased patient participation through the development of their GP Practice Patient Reference Groups (PRG's) as a way in which practices can regularly engage with their patients and gain ongoing patient feedback on their services.

In June 2015 we hosted an event during national patient participation week, showcasing the advantages of PRGs by celebrating local successes alongside offering practical guidance and support to help with the establishment of new PRGs

or the development of existing ones. This also included a brief introduction to the Barnsley Patient Council and Healthwatch Barnsley and the role that PRG members can play in supporting and working alongside these organisations.

Attendees were able to discuss and share their experiences of both good practices and the challenges they had encountered within their own groups as well as network and share contacts.

- New Primary Care Contracts

In early summer we held a consultation on the provision of GP services with the Brierley Medical Centre. Three drop-in sessions were well attended and 169 surveys were completed to feed into the commissioning process.

2.2.5. Contribution to the delivery of joint Health and Wellbeing Strategies

Barnsley's Health & Wellbeing Board aims to improve the health and wellbeing for the residents of Barnsley and reduce inequalities in health outcomes. The board commissions and approves the Joint Strategic Needs Assessment (JSNA), commissions and approves the Joint Health and Wellbeing Strategy, approves and oversees the Better Care Fund, sets the health and social care commissioning framework, is the focal point for health and wellbeing decision making, and drives collaboration, integration and joint commissioning. We are represented on the board by both our Chair and our Chief Officer.

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.

2.2.6. Sustainability

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.

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.

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.

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

For more information visit our website http://www.barnsleyccg.nhs.uk/strategies-policies-and-plans.htm

3. Signature of the Performance Report by the Accountable Officer

Lesley Smith
Accountable Officer
26 May 2016

SECTION 2

Accountability Report

Accountability Report

4. Corporate Governance Report

4.1. Members' Report

4.1.1. Member Practices

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

4.1.2. Composition of the 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.

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.

The members of our Governing Body during 2015-16 are shown below:

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	9/13 (69%)
Dr John Harban	Elected Member	1 April 2013	11/13 (84%)
Dr Sudhagar Krishnasamy	Elected Member	1 April 2013	10/13 (76%)
Dr Nick Luscombe	Elected Member	1 April 2013	12/13 (92%)
Dr Madhavi Guntamukkala	Elected Member	1 April 2015	10/13 (76%)
Dr Lawrence King	Elected Member	1 April 2015	11/13 (84%)
Dr Mark Smith	Elected Member	1 April 2015	10/13 (76%)
Anne Arnold	Lay Member Representative for Governance	1 April 2013 – 30 June 2015	3/4 (75%)

Name	Position on the Governing Body	Appointment dates	Attendance record
David O'Hara	Lay Member Representative for Governance	1 September 2015 – 7 March 2016	6/6 (100%)
Chris Millington	Lay Member Representative for Patient and Public Engagement and Primary Care Commissioning	1 April 2015	13/13 (100%)
Marie Hoyle	Practice Manager Member	1 April 2013	12/13 (92%)
Mike Simms	Secondary Care Clinician	1 September 2013	11/13 (84%)
Brigid Reid	Chief Nurse	1 April 2013	11/13 (84%)
Lesley Smith	Chief Officer (and Accountable Officer)	28 July 2014	12/13 (92%)
Heather Wells	Chief Finance Officer	23 February 2015	10/13 (76%)

In addition, the Chief of Corporate Affairs, Vicky Peverelle, attends Governing Body meetings but does not vote. She has attended all 13 meetings.

Profiles of the Governing Body members, details of conflicts of interest they have declared, and other relevant information can be found on the CCG's website www.barnsleyccg.nhs.uk/about-us/governing-body.htm

During 2015-16 the following members of the Governing Body were members of the CCG's Audit Committee: Anne Arnold (to June 2015), David O'Hara (from September 2015), Dr Madhavi Guntamukkala, Chris Millington, and Marie Hoyle. In addition one Member of the Membership Council, Dr Jeroen Maters, was also a Member of the Audit Committee.

4.1.3. Composition of other Committees

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

- Primary Care Commissioning Committee
- Quality & Patient Safety Committee
- Patient and Public Engagement Committee
- Finance and Performance Committee,
- Clinical Transformation Board, and an
- Equality Steering Group.

Details of the functions, membership, and attendance records of each of these Committees can be found in the Governance Statement.

4.1.4. Register of Interests

A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship.

We require interests to be declared on appointment in writing, at meetings, on changing roles or responsibilities, on any other change of circumstances, and at specific points during the procurement process.

Profiles of the Governing Body members, details of conflicts of interest they have declared, and other relevant information can be found on our website www.barnsleyccg.nhs.uk

4.1.5. Personal data related incidents

We have had no Information Governance Serious Incidents Requiring Investigation (IG SIRI) reportable to the Information Commissioner in the past year.

4.1.6. Statement as to Disclosure to Auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware; and that they have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

4.1.7. 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) and the CCG Assurance Framework. For details of how the CCG has ensured compliance with its statutory duties please see the Governance Statement.

4.2. 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 the appropriate 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.

Lesley Smith,
Accountable Officer
26 May 2016

4.3. Governance Statement

4.4. Introduction and context

NHS Barnsley Clinical Commissioning Group (CCG) was licensed from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006. As at 1 April 2015, the CCG continues to be licensed without conditions.

The CCG has continued to develop its governance arrangements. 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 1 April 2015. In consequence:

- the Constitution and Corporate Manual have been thoroughly reviewed and updated
- the CCG has strengthened its Conflicts of Interest Policy to adhere to the new statutory guidance issued by NHS England in December 2014
- a new Primary Care Commissioning Committee (PCCC) has been established to discharge the delegated functions. The Committee has a Lay and Executive majority to facilitate effective decision making where conflicts of interest arise. It meets in public, and is attended by Healthwatch Barnsley, local authority Public Health, and NHS England, which ensures transparency and accountability in its decision making.

The CCG's governance and management of conflicts of interest with respect to the way the PCCC discharges the delegated functions has been reviewed by the internal auditors, 360 Assurance, during the year and found to be effective and compliant with relevant guidance.

During 2015/16 NHS England has continued to oversee the performance and development of the CCG through its continuous assurance process. The CCG has received a provisional assessment of 'good' for all domains (well led organisation, delegated functions, financial management, performance, and planning). The CCG has also self-certified its arrangements as 'good' in respect of the delegated responsibilities for commissioning primary medical services.

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.

4.5. 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.

4.6. Compliance with the UK Corporate Governance Code

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

We have self-assessed our arrangements against the UK Corporate Governance Code and are satisfied we are compliant with those aspects relevant to the CCG.

4.7. The CCG governance framework

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

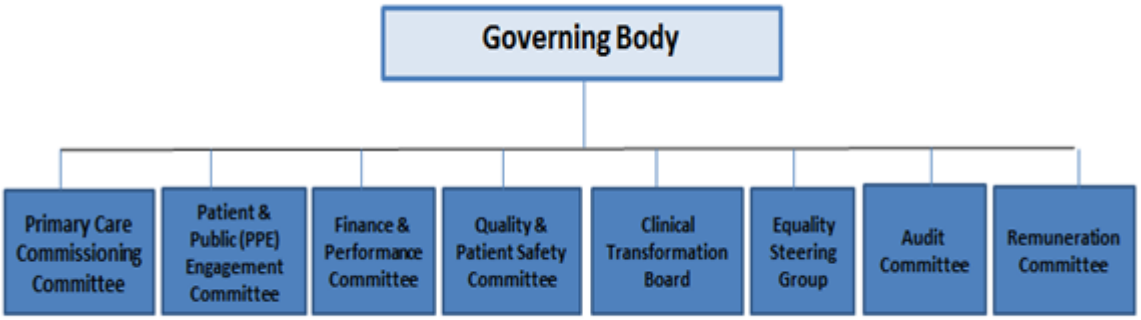
The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

This section provides details of how this has been achieved.

4.7.1. 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 8 members to the Governing Body. The Membership Council has met 7 times during 2015/16. 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:



4.7.2. 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 2015/16 Annual Report provides details of the Governing Body members including their attendance records and declared interests (section 4.1.2), and the remuneration paid to senior managers (in the Remuneration Report).

4.7.3. 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 (http://www.barnsleyccg.nhs.uk/about-us/committees.htm). Minutes of all Committees are reported to the Governing Body, significant matters are escalated through the Risk Management Framework (described at section 4.8), and Governing Body Members sit on the Committees.

Each Committee produces and presents to the Governing Body an Annual Assurance 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 on the next pages:

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 – April to June 2015)	Anne Arnold	4/4 (100%)
Governance Lay Member (Chair – September 2015 to March 2016)	David O'Hara	3/3 (100%)
PPE & Primary Care Commissioning Lay Member	Chris Millington	5/7 (71%)
Elected Governing Body Member	Dr M Guntamukkala	5/7 (71%)
Practice Manager Governing Body Member	Marie Hoyle	7/7 (100%)
Member of the Membership Council	Dr J Maters	5/7 (71%)

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 N Balac	11/12 (92%)
Governance Lay Member (April – June 2015)	Anne Arnold	2/3 (67%)
Governance Lay Member (Sept-15 – March-16)	David O'Hara	8/8 (100%)
Elected Governing Body Member	Dr J Harban	10/12 (83%)
Elected Governing Body Member	Dr N Luscombe	9/12 (75%)
Elected Governing Body Member	Dr M Guntamukkala	9/10 (90%)
Member of the Membership Council	Mr James Logan	4/5 (80%)
The Chief Officer	Lesley Smith	11/12 (92%)
The Chief Finance Officer	Heather Wells	8/12 (67%)
Chief of Corporate Affairs	Vicky Peverelle	8/12 (67%)

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 M Ghani	11/11 (100%)
Chief Nurse (Deputy Chair)	Brigid Reid	11/11 (100%)
Governing Body Secondary Care Clinician	Mike Simms	8/11 (73%)
Member of the Membership Council (clinical advisor)	Dr R Farmer (as of September 2015)	4/6* (67%)
Member of the Membership Council (clinical advisor)	Dr M Kadarsha	5/11 (45%)
Elected Governing Body Member	Dr M Smith	10/11 (91%)
Elected Governing Body Member	Dr S Krishnasamy	7/11 (64%)
PPE & Primary Care Lay Member	Chris Millington	9/11 (82%)
Head of Medicines Management	Chris Lawson	7/11 (64%)
Deputy Chief Nurse	Karen Martin (April-July 2015) Martine Tune (Aug 2015-March 2016)	3/3 (100%) 8/8 (100%)
Head of Quality for Primary Care Commissioning	Karen Martin (Aug 2015-March 2016)	8/9 (89%)

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 & Primary Care Lay Member (Chair)	Chris Millington	5/5 (100%)
Chair or Chief Officer of the Governing Body	Dr N Balac	0/5 (0%)
	Lesley Smith	1/5 (20%)
Chief Nurse	Brigid Reid	5/5 (100%)
Governing Body Secondary Care Clinician	Mike Simms	5/5 (100%)
Elected Governing Body Member	Dr L King	4/5 (80%)
Practice Manager Governing Body Member	Marie Hoyle	5/5 (100%)
Member of the Membership Council	Vacant	
Chief of Corporate Affairs	Vicky Peverelle	4/5 (80%)
Communications and Engagement Lead	Kirsty Waknell	5/5 (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	3/3 (100%)
PPE & Primary Care Lay Member	Chris Millington	2/3 (67%)
Elected Governing Body Member	Dr L King	1/3 (33%)
Member of the Membership Council	Dr I Saxena	2/3 (67%)
Member of the Membership Council	Vacant	
Practice Manager Governing Body Member	Marie Hoyle	3/3 (100%)
Deputy Chief Finance Officer (Contracting)	Patrick Otway	2/2 (100%)
Head of Contracting	Amanda Capper	1/1 (100%)
Head of Assurance	Richard Walker	3/3 (100%)

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 (April-June 2015) David O 'Hara (Sep 2015-March 2016)	1/1 (100%) 1/1 (100%)
PPE Lay Member (Deputy Chair)	Chris Millington	3/3 (100%)
Chair of the Governing Body	Dr N Balac	2/3 (67%)
Elected Governing Body Member	Dr J Harban	1/3 (33%)
Elected Governing Body Member	Dr N Luscombe	3/3 (100%)
Practice Manager Governing Body Member	Marie Hoyle	2/3 (67%)
Governing Body Secondary Care Clinician	Mike Simms	2/3 (67%)

Primary Care Commissioning Committee

Function Makes collective decisions on the review, planning and procurement of primary care services in Barnsley, including functions under delegated authority from NHS England. The Committee manages the delegated allocation for commissioning of primary care services in Barnsley.		
Assurance provided to the Governing Body Provides assurance to the Governing Body that the functions delegated to the CCG have been appropriately discharged, with regard to outcomes for patients, the management of any conflicts of interest, primary care procurement and contract management, and the availability of services.		
Membership and attendance		
Role	*Name*	*Meetings attended*
PPE and Primary Care Lay Member (Chair)	Chris Millington	11/11 (100%)
Governance Lay Member (Vice Chair)	Anne Arnold (April to June 2015) David O'Hara (September 2015-March 2016)	0/3 (0%) 5/5 (100%)
Chief Officer	Lesley Smith	11/11 (100%)
Chief of Corporate Affairs	Vicky Peverelle	10/11 (90%)
Chair of the Governing Body	Dr N Balac	7/11 (63%)
Medical Director	Dr M Ghani	7/11 (63%)
Elected Governing Body member	Dr M Guntamukkala	9/11 (81%)

Clinical Transformation Board

Function Prioritises the commissioning and development work of the CCG to ensure interdependent projects are linked and have the required level of clinical evidence to be implemented.		
Assurance provided to the Governing Body Assurance that the CCGs Service Development resource is directed to key projects that will bring care closer to home and facilitate the achievement of CCG objectives.		
Membership and attendance		
Role	*Name*	*Meetings attended*
Chair of the Governing Body (Chair)	Dr N Balac	6/8 (75%)
Medical Director	Dr M Ghani	7/8 (88%)
Elected Governing Body Member	Dr J Harban	2/8 (25%)
Elected Governing Body Member	Dr M Smith	2/8 (25%)*
Elected Governing Body Member	Dr S Krishnasamy	6/8 (75%)
Governing Body Secondary Care Clinician	Mike Simms	7/8 (88%)
Chief Nurse	Brigid Reid	7/8 (88%)
PPE and Primary care Lay Member	Chris Millington	8/8 (100%)
Chief Officer	Lesley Smith	7/8 (88%)
Chief of Corporate Affairs	Vicky Peverelle	5/8 (63%)

*Dr M Smith attended all meetings he was requested to attend

4.7.4. 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.

4.7.5. Better Care Fund

The Better Care Fund (BCF) was established from 1 April 2015, in line with NHS England and Local Government Association directions. The aim of the BCF is to support transformation and integration of Health and Social Care in line with the Health and Wellbeing Strategy for Barnsley.

A governance structure and pooled budget arrangements for the BCF has been agreed with Barnsley MBC and formalised in a Section 75 agreement which provides for reporting on BCF indicators through to the CCG's Committee structure to the Governing Body. The Senior Strategic Development Group (SSDG) as a sub-committee of the Health & Wellbeing Board oversees progress with the Better Care Fund and its role includes escalation of risks and issues to the Health and Wellbeing Board and the CCG's Governing Body through its membership. There is clear CCG senior management ownership and leadership of the BCF and clinical involvement through GP membership of the Governing Body and as Vice Chair of the Health and Wellbeing Board.

4.7.6. Information about South Yorkshire Commissioners and Providers Forum

The role of CCG COM, Working Together Commissioners and the Acute Care Collaborative Vanguard 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. CCG COM, Working Together Commissioners and the Acute Care Collaborative Vanguard Providers Forum 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.

4.7.7. Effectiveness of the Governing Body

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

- Following a number of changes to the membership of the Governing Body from 1 April 2015 a Governing Body away day was held in April 2015 focused on the CCG's vision and strategy, successes and challenges, and arrangements for driving transformation going forward.
- Further development sessions have been held at regular intervals through the year covering issues such as risk and assurance management, the NHS financial regime, Child and Adolescent Mental Health Services, and the CCG's strategic direction of travel.
- Individual personal development reviews (PDRs) have been undertaken with Governing Body members by the CCG Chair.
- The Governing Body participated in a self-assessment, facilitated by 360 Assurance, using the Good Governance Institute's Maturity Matrix in January 2016. The self-assessment identified a number of areas where the Governing Body felt it had already reached a strong level of maturity, and generated ideas for further improvement in the way the CCG communicates with its member practices, and on improving its focus on outcomes.
- The CCG completed a self-assessment against the Well Led Organisation elements of the NHS England CCG Assurance Framework in March 2016. The self-assessment rated the CCG as 'good' or 'outstanding' across all the key indicators.

4.8. The CCG's risk management framework

4.8.1. 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 is 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 most recently in October 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 of the 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 focused 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.

4.8.2. 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.

This results in 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
	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, Committees receive and consider extracts of both the Assurance Framework and Risk Register, and escalate significant matters to the Governing Body. Red and amber risks are considered at every meeting, yellow and green risks twice a year. 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 2015/16. A Governing Body development session in May 2015 refreshed the Governing Body's understanding of the CCG's approach to risk management and assurance, and fully reviewed and updated the risks to the CCG's strategic objectives in the Governing Body Assurance Framework. A development session was held for Audit Committee members in January 2016 where the format and content of the Assurance Framework was considered. The session generated some ideas for further enhancement of the Framework which will be incorporated into the next refresh, scheduled for April 2016.

4.8.3. 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.

- 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.

- The CCG is fully committed to **complying with the public sector equality duty 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 attends to make sure the patient's viewpoint is heard. The CCG has a full suite of human resources policies 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.

- 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 undertakes a wide range of proactive work to 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 also undertakes proactive detection exercises, and investigations into potential frauds. The LCFS presents reports to every Audit Committee, and also prepares an Annual Report. The LCFS submitted an initial assessment of the CCG's level of compliance with NHS Protect's *Standards For Commissioners* in July 2015 which overall judged the CCG to be at 'amber.' This means the CCG has appropriate arrangements in place but that more evidence is required of their effectiveness in some areas. An action plan was agreed and is currently being implemented by the LCFS and CCG officers.

- The CCG has robust arrangements to ensure its **Health and Safety** responsibilities are effectively discharged. A Health and Safety Group, reporting to the Audit Committee, is supported by experts from YHCS initially (now in housed by CCGs hosted by Doncaster CCG). This group is also attended by staff side as well as CCG employees, and meets three times a year. 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. The CCG's risk assessments indicated a low risk in

respect of fire and health and safety. All CCG staff receive mandatory training in fire and health and safety.

4.8.4. Involvement of public stakeholders

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:

- The CCG has a Governing Body Lay Member for Patient and Public Engagement and a Patient and Public Engagement Committee responsible for overseeing the CCG's arrangements in this area
- Members of the public attend meetings of the Governing Body and Primary Care Commissioning Committee
- The Annual General Meeting, held in June 2015, was held at the Digital Media Centre in Barnsley and was attended by 46 members of the public from a wide range of stakeholders
- The Our Public Engagement Network (OPEN) has been created, enabling the CCG to gather views of carers, patients, and members of the public to inform key commissioning decisions
- The CCG works closely with Healthwatch Barnsley, which attends the Equality Steering Group and 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 and PRG representatives 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.

4.8.5. How do the control mechanisms work?

The CCG has a robust internal control mechanism to allow it to prevent, manage and mitigate risks. Section 4.7.3 describes the governance structure of the CCG, section 4.8 describes the approach to risk management, and section 4.8.1 explains the key components of the internal control structure. Taken together these arrangements underpin the CCG's ability to control risk through a combination of:

- *Prevention* – the CCG's structures, governance arrangements, policies, procedures, and training minimise the likelihood of risks crystallising.
- *Deterrence* – staff are made aware that failure to comply with key policies and procedures, such as the Standards of Business Conduct Policy or the Fraud,

Bribery and Corruption Policy, will be taken seriously by the CCG and could lead to disciplinary action, or dismissal.

- *Management of risk* – once risks are identified the arrangements for ongoing monitoring and reporting of progress through the Committee structure to the Governing Body ensure appropriate action is taken to manage risks.

4.8.6. Risk Assessment

The CCG's process for identifying, rating, and responding to risks was described in sections 4.8.2 and 4.8.3 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 2015	5	23	13	2
Sept 2015	4	26	10	2
March 2016	6	26	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 2016
YAS non achievement of response and turnaround time targets – quality impacts	There has been ongoing work with YAS to better understand and mitigate impact of under-performance on the quality and safety of care for Barnsley residents, through breach analysis, review of serious incidents etc. Detailed reports have been received and reviewed by the GB. YAS Senior Managers met with the CCG Governing Body in March 2015, and issues have also been raised directly with NHSE. A YAS summit in October 2015 identified a range of actions aimed at improving contract performance and providing assurance over service quality. A quality and safety event for commissioners was held on 13 November where YAS set out their Quality strategy for the year ahead.	Ongoing assessment of impact of breaches on quality and patient safety	**3x5 = 15**
YAS non achievement of response and turnaround time	YAS agreed a rectification plan to meet the standard following discussions at the CCG Governing Body. BCCG contracts staff working closely with lead commissioner (SCCG) contracts	Performance against targets	**4x5 = 20**

targets – performance / reputational impacts	lead. Local discussions are held regularly and local actions agreed to improve performance in Barnsley. YAS Senior Managers met with the CCG Governing Body in March 2015 in light of ongoing poor performance. A YAS summit in October 2015 identified a range of actions aimed at improving contract performance and providing assurance over service quality.		
NHS Constitution pledge regarding Accident and Emergency (A&E) 4 hour waits not delivered by BHNFT	The 95% target was not achieved in 2015/16. Actions are in place to deliver improved performance going forward. A health community whole system -wide response is being led by the CCG. An SRG 4 Hour System Wide plan is in place and being implemented to increase capacity and resilience across the health and care system. IHEART Barnsley has been established and is now operational offering, out of hours GP appointments on evenings and Saturdays.	Delivery of targets in the commissioning plan	**4x4 = 16**
Potential impact on quality & patient safety of incomplete D1 discharge letters	Improved D1 completion was included within the core contract for 2015/16 with financial penalties if not met. New D1 templates were endorsed by Membership Council at its July 2015 meeting. BHNFT has progressed some work against an action plan submitted to the Area Prescribing Committee in September 2015 which, coupled with the introduction of an adapted ICE discharge letter may achieve 80% accuracy on all discharge letters by the end of March 2016. However there has been no re-audit of D1 quality undertaken and the introduction of a new IT system, planned for spring 2016, has no definite implementation date.	Audit of discharge letters	**4x4 = 16**
If the 0-19 path-way re-procurement by Public Health leads to a reduction in service there is a risk of negative impact on primary care workforce & capacity.	The CCG is in ongoing discussions with the Council through our Chair, Chief Officer and Chief Nurse to establish how we can ensure that the service will be the best for people of Barnsley. BMBC, SWYPFT and the CCG are continuing to discuss the optimum solutions to deliver high quality services for this patient group.		**4x4=16**
Risks arising if the Barnsley area continues to experience a	NHS England's Primary Care Strategy includes a section on workforce planning. The CCG's Primary Care Development Programme has a workforce workstream. Links have been	Monitored by PCCC	**4x4=16**

lack of GPs in comparison with the national average, due to GP retirements, inability to recruit etc.	developed with the Medical School to enhance attractiveness of Barnsley to students. The CCG continues to invest in primary care capacity. The PDA enables practices to invest in the sustainability of their workforce. The innovation Fund saw £0.25m invested in developing new, more efficient and flexible ways of working. The successful PMCF has enabled additional capacity to be made available outside normal hours via the I Heart Barnsley Hubs. The CCG is also creating 4 GP fellowships in partnership with SWYPFT		
BHNFT failure to deliver diagnostic test targets	At the start of the year inconsistent performance led to this target being risk assessed as red (15). During the first half of 2015/16 the CCG's contracting team worked closely with the Trust on options to increase capacity and performance, and an action plan was put in place at BHNFT to increase capacity to address non - obstetric ultrasound waiting time pressures. As a result performance improved sufficiently to warrant the reduction in this risk to a score of amber (9).	Performance against target	**3x3 = 9**
Risk of non-delivery of infection control trajectories	At the start of the year this was scored as 16 (red). However the CCG undertook a re-procurement exercise for a new infection control service which became operational from 1 October 2015. The CCG is on course to meet its trajectories for both C Difficile and MRSA in 2015/16 and as such the risk has been reduced to 8 (amber).	Performance against trajectories	**2x4=8**

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 2016/17 for those risks which remain open.

A development session was held April 2016 for the Governing Body to identify any new or significantly changed challenges to the delivery of its objectives in 2016/17. Any new risks will be reflected in the 2016/17 Governing Body Assurance Framework and Risk Register and appropriate mitigating actions put in place to address them.

4.8.7. Principal risks to compliance with the CCG licence

There are currently no principal risks to the CCG's licence as at 31 March 2016.

4.9. 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 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 (the Constitution and Corporate Manual have both been reviewed and updated during 2015/16)
- 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 4.7)
- The CCG's management structure, with responsibilities clearly allocated to teams and individuals
- The Risk Management Framework (see 4.8)
- 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 continuous assurance process.

4.9.1. 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 http://www.barnsleyccg.nhs.uk/about-us/governing-body.htm . It is also considered at the public session of the Governing Body twice a year. 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. On a quarterly basis all staff are requested to review and update their entries in the Register.

The CCG's Conflicts of Interest Policy, which sets out the approach to managing conflicts, is incorporated within the Standards of Business Conduct Policy which was reviewed, clarified and strengthened in January 2015 to address the requirements of new statutory guidance issued by NHS England in December 2014. Key enhancements included:

- The establishment of a Primary Care Commissioning Committee with a Lay and Executive majority to enable effective management of Conflicts of Interest arising in respect of the CCG's delegated responsibility for commissioning primary medical services
- The creation of a publicly available Register of Procurement Decisions setting out how any conflicts arising in the course of the CCG's procurement activity had been managed

- The use of a primary care procurement checklist provided by NHS England giving detail of how conflicts have been managed, and
- The extension of the CCG's Register of Interests to cover senior staff working in member Practices.

The CCG's internal auditor, 360 Assurance, has reviewed the CCG's approach to managing conflicts of interest in respect of its delegated functions and found the arrangements to be robust.

4.9.2. Commissioning Support

During 2015/16 the CCG bought a range of support services from **Yorkshire and Humber Commissioning Support (YHCSU)** under a Service Level Agreement supported by detailed work plans. The CCG appointed a Governing Body level 'intelligent client' for each area of service who met on a monthly basis with the CSU's named lead for their area. In addition, there were monthly contract monitoring meetings with YHCSU'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. The report covers a range of controls relevant to Accounts Payable, Accounts Receivable, Financial Ledger, Financial Reporting, Treasury & Cash Management, Payroll, HR and Workforce. This report is also taken into account by the Head of Internal Audit in forming his overall opinion. The final 2015/16 report was received in April 2016 and has been reviewed as part of the year end process. Whilst the report identifies a small number of controls which were not functioning as designed, the CCG is of the view that the issues identified do not represent a significant risk to the CCG in terms of materiality or in the light of other compensating controls operated by the CCG.

YHCSU was not successful in securing a place on NHS England's Lead provider Framework for commissioning support services. As a result YHCS ceased its service provision from 1 April 2016. Barnsley CCG has worked closely with NHS England and other CCGs during 2015/16 to review its commissioning support requirements and secure appropriate, cost effective alternative provision.

All commissioning decisions were taken based upon business cases reviewed and approved by NHS England. The CCG has:

- Brought its communications and engagement function back in house

- Sourced a number of services, including HR, Health and Safety, and Equality & Diversity, via local shared service arrangements hosted by other CCGs, and

- Participated in a region-wide procurement exercise to purchase Information Technology, Information Governance, and Business Intelligence services from the Lead Provider Framework (the successful bidder was a private sector consortium, eMBED).

The CCG has developed assurance processes for these services. The local shared service arrangements are underpinned by Memorandums of Understanding and regular meetings are held between Chief Officers of the CCG and service providers. The CCG is represented on the Mobilisation Board overseeing the mobilisation of the IT and BI contract which went live on 1 April 2016.

4.9.3. Third party assurances

Service Organisations (including CSUs) do not generally allow access to client auditors, as this is an inefficient approach to providing assurance, costly for clients commissioning the work and disruptive to the Service Organisation. Service Auditor Reports (SARs) are an internationally recognised method for Service Organisations to provide details of controls and their operation in a specified period to their clients.

A SAR typically includes a high level description of the governance and assurance arrangements in place at the Service Organisation, a high level description of the Service control environment, an assertion by the Service Organisation management regarding the design of internal controls over the process, and a low level description of the Service's control objectives and supporting key controls.

The CCG received and reviewed the following SARs after the submission of the draft accounts:

- From CSU(s) for some or all services provided (as agreed between the CCG and CSU annually) – see previous section
- From NHS Shared Business Services for the provision of Financial and Accounting Services
- From McKesson / IBM for the Electronic Staff Records Programme (ESR)
- From NHS England over Co-Commissioning Recharges
- From NHS Business Service Authority regarding Prescription Services.

Whilst these reports identified a small number of controls which were not functioning as designed, the CCG is of the view that the issues identified do not represent a significant risk to the CCG in terms of materiality and in the light of other compensating controls operated by the CCG.

On 25 May 2016 the CCG received the Service Auditor Report by PwC regarding HSCIC's GP Payments Services. The report provides good assurance for the majority of the controls tested, and for the GP Payments System it raised no material issues. In respect of the Calculating Quality and Reporting Service (CQRS), which is used to calculate payments under the Quality and Outcomes Framework (QOF), the report does however identify some control issues with respect to user access rights to the system which caused PwC to qualify their opinion. In the opinion of HSCIC's management the control weakness identified are not of a nature that could result in a risk of material accounting misstatement in costs processed through the HSCIC delivered systems, since there are appropriate mitigating controls in place. HSCIC accepts that there is a requirement to strengthen some aspects relating to this control.

Although this SAR does not provide full assurance the CCG takes additional assurance from its own internal control procedures that co-commissioning expenditure has been incurred and is reflected correctly in the financial statements. The CCG receives a full download of NHS England's ledger each month, which reconciles to the journals posted to the CCG's ledger. Transactions are reconciled and agreed with NHS England each month. Expenditure, including QOF expenditure, is monitored against budgets on a monthly basis, and is reported to the Primary Care Commissioning Committee.

It is therefore the CCG's view that the issues identified in the HSCIC letter do not represent a significant risk to the CCG in terms of materiality and in the light of other compensating controls operated by the CCG

4.9.4. 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 CCG, 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. We have established an information governance management framework and supporting processes and procedures in line with the Information Governance Toolkit. We ensure all staff undertake annual information governance training to ensure staff are aware of their information governance roles and responsibilities. There are processes in place for incident reporting and investigation.

Based on these arrangements the CCG was able to report full compliance across all standards in its 2013/14 and 2014/15 IG Toolkit submissions. Notwithstanding this success, the CCG has continued to further embed and enhance its IG arrangements during 2015/16.

Key improvements have included:

- Further developing information risk assessment and management procedures by providing additional training and support for Information Asset Owners, updating the register of the CCG's key information assets, and undertaking an IG Security Audit with findings shared across the CCG.
- Good practice in relation to IG has been disseminated through the organisation through direct email communications and the intranet
- Working with partners to ensure information is shared safely within Barnsley e.g. through the establishment of regular Barnsley IG Leads meetings, working closely with staff engaged in service transformation projects to ensure IG requirements are addressed, and supporting Barnsley GP practices to safely implement the Medical Interoperability Gateway (MIG).

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 2016 and provided a significant assurance opinion. The CCG subsequently submitted a fully compliant IG Toolkit assessment for 2015/16.

4.9.5. Review of Economy, Efficiency and Effectiveness of the Use of Resources

Throughout 2015/16 the Governing Body has built upon the experience of the first two years of operation with regard to making investment decisions and identifying efficiency programmes. The Governing Body has exercised control via 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 pound, recurrent investments have been approved after consideration of alignment with strategic objectives and non-recurrent investment has been deployed to secure operational imperatives, such as winter resilience. In addition, an in depth mid-year financial review was undertaken to re-evaluate affordability prior to existing plans moving forward to implementation.

Stronger emphasis has been placed in the last year on delivering efficiencies, which has been brought into even sharper focus as we prepared plans for 2016/17 and beyond. The CCG has begun to focus on the NHS RightCare approach and commissioning for value, in order to deliver the best value for the Barnsley pound.

Robust budgetary control procedures, along with detailed financial management policies have been reviewed and revised. As part of budgetary control, the Finance and Performance Committee and Governing Body have received regular Integrated Performance Reports which highlight financial performance in the context of activity, projected year-end position and the identification and proposed management of key risks. The CCG contained expenditure within allocated resources, both for Programme and Running Costs and has ended the year with a surplus of £8.28 million, in line with NHS England expectations. It is anticipated that, after NHS England approval of drawdown of this surplus in future years, it will be deployed to pump-prime initiatives to focus on securing efficiencies over the longer term.

Third party assurance is provided by Internal Audit in relation to the effectiveness of the CCG's key financial systems and External Audit provide an opinion in relation to the CCG's use of resources in their Value for Money (VFM) conclusion.

4.10. Review of the Effectiveness of Governance, Risk Management, and Internal Control

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

4.10.1. Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Officer as Accountable Officer. The Governing Body collectively ensures that robust systems of internal control and management are in place. These arrangements, and the enhancements that have been made to them during 2015/16, are described in detail at sections 4.7 to 4.9 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 2015/16 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. Governing Body and Committee reporting arrangements 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.

4.10.2. 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 outcomes from assurance checkpoint meetings with NHSE (see section 4.4)
- The CCG's overall governance, risk management, and internal control arrangements (see sections 4.7 to 4.9)
- 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 with the exception of a review of Continuing Healthcare, which received a 'limited assurance' opinion. This review found that in all cases sampled the correct decision had been reached, but there were a number of procedural issues. Some of these were historic, and had already been identified and addressed by the CCG. An action plan is in place to address the remaining issues as soon as possible.
- Performance, equality, sustainability, and other information incorporated within the Annual Report and other performance information available to her
- 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 2015/16.

Section 4.8.6 above sets out the significant control issues identified in the year and the actions taken to address them.

4.10.3. 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:

"From my review of your systems of internal control, primarily through the operation of your Governing Body Assurance Framework (GBAF), risk management arrangements, individual assignments and follow-up of actions I have undertaken, I am providing Significant Assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently."

Internal Audit has not issued any reports which identified governance, risk management, or control issues which were significant to the CCG.

4.10.4. 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 a wide range of sources of assurance available to the CCG to monitor the quality of this data – national datasets, local audits, data quality targets, contractual requirements etc. Internal Audit has recently undertaken a review of the CCG's approach and the CCG will implement the recommendations to ensure sufficient appropriate assurance is obtained and reported by the CCG.

4.10.5. Business Critical Models

The CCG has no business critical models which meet the required threshold for reporting to the Department of Health (via NHS England) in line with the recommendations from the MacPherson report.

4.10.6. Data security

As described in section 4.9.2, the CCG has submitted a satisfactory level of compliance with the IG Toolkit assessment in 2015/16. There have been no Serious Untoward Incidents relating to data security breaches during 2015/16.

4.10.7. 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 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 and work plans, as described at sections 4.7 to 4.10 above. These arrangements have been subject to external scrutiny through a range of processes, including the NHS England CCG Assurance Framework, as highlighted in section 1.4.1.

From 1 April 2015 the CCG has had delegated responsibility from NHS England for commissioning primary medical services under a signed Delegation Agreement. NHS England's CCG Assurance Framework requires the CCG to submit a quarterly self-certification and declaration of compliance with its delegated responsibilities. The CCG has self-certified its arrangements as 'good' through this process. Internal Audit has reviewed the CCG's arrangements for discharging its delegated functions and found them to be robust.

During 2015/16 the Constitution has been subject to further review and amendments have been made to:

- Clarify terms of office of Governing Body members
- Clarify the eligibility criteria to be a Practice Representative on the Membership Council
- Incorporate the Clinical Transformation Board within the CCG's governance structure
- Update the Standing Orders to reflect recent changes in Committee Terms of Reference (roles, membership etc.)
- Correct any typographic errors etc.

All of the above changes were reviewed and approved by NHS England in January 2016.

4.11. 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.

Lesley Smith
Accountable Officer
26 May 2016

5. Remuneration and Staff Report

5.1. Remuneration policy

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. The CCG has not implemented any performance related pay.

5.2. Remuneration Report Tables

The following tables reflect the salaries and allowances and pension benefits for senior managers with the CCG during 2015/16.

5.2.1. Salaries and Allowances SUBJECT TO AUDIT

Name and title	(a) Salary (bands of £5,000)		(b) Expense payments (taxable) to nearest £100		(c) Performance pay and bonuses (bands of £5,000)		(d) Long term performance pay and bonuses (bands of £5,000)		(e) All pension-related benefits (bands of £2,500)		(f) TOTAL (a to e) (bands of £5,000)	
	£000		£00		£000		£000		£000		£000	
	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16	14/15	15/16
Dr N Balac, Chairman	75-80	**105-110**	0	**0**	0	**0**	0	**0**	0-2.5	**22.5-25**	80-85	**130-135**
M Wilkinson, Chief Officer (to 27.07.2014)	40-45	**0**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**0**
L J Smith, Chief Officer (from 28.07.2014)	95-100	**130-135**	0	**0**	0	**0**	0	**0**	0	**0**	95-100	**130-135**
Dr M Ghani, Medical Director	95-100	**75 -80**	0	**0**	0	**0**	0	**0**	22.5-25	**52.5-55**	120-125	**130-135**
C Hobson, Chief Finance Officer (to 20.02.2015)	85-90	**0**	0	**0**	0	**0**	0	**0**	0	**0**	85-90	**0**
H Wells, Chief Finance Officer (from 20.02.2015)	45-50	**95 -100**	0	**0**	0	**0**	0	**0**	0	**30-32.5**	45-50	**125-130**
B Reid, Chief Nurse**	85-90	**85-90**	0	**0**	0	**0**	0	**0**	95-97.5	**17.5-20**	180-185	**100-105**
V Peverelle, Chief of Corporate Affairs	0	**80-85**	0	**0**	0	**0**	0	**0**	0	**25-27.5**	0	**105-110**
K Martin, Acting Chief Nurse (01.11.2014 to 28.02.2015)	70-75	**0**	0	**0**	0	**0**	0	**0**	10-12.5	**0**	80-85	**0**
Dr C Bannon, Governing Body Member	40-45	**0**	0	**0**	0	**0**	0	**0**	7.5-10	**0**	45-50	**0**
Dr J Harban, Governing Body Member*	25-30	**25-30**	0	**0**	0	**0**	0	**0**	137.5-140	**5-7.5**	165-170	**35-40**
Dr N Luscombe, Governing Body Member*	25-30	**35-40**	0	**0**	0	**0**	0	**0**	260-262.5	**0**	290-295	**35 -40**
M Hoyle, Governing Body Member (Practice Manager)	15-20	**15-20**	0	**0**	0	**0**	0	**0**	0	**0**	15-20	**15-20**
J Logan, Governing Body Member	25-30	**0**	0	**0**	0	**0**	0	**0**	0	**0**	25-30	**0**
Dr R Farmer, Governing Body Member*	25-30	**0**	0	**0**	0	**0**	0	**0**	165-167.5	**0**	190-195	**0**
Dr S Krishnasamy, Governing Body Member*	25-30	**25-30**	0	**0**	0	**0**	0	**0**	127.5-130	**5-7.5**	155-160	**30-35**
Dr M Guntamukkala, Governing Body Member	0	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	0	**25-30**
Dr M Smith, Governing Body Member	0	**25-30**	0	**0**	0	**0**	0	**0**	0	**0**	0	**25-30**
Dr M Simms, Governing Body Member	10-15	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**10-15**
Dr L King, Governing Body Member	0	**20-25**	0	**0**	0	**0**	0	**0**	0	**0**	0	**20-25**
C Ruddlesdin, Lay Member	10-15	**0**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**0**
A Arnold, Lay Member	10-15	**0-5**	0	**0**	0	**0**	0	**0**	0	**0**	10-15	**0-5**
C Millington, Lay Member	0	**10-15**	0	**0**	0	**0**	0	**0**	0	**0**	0	**10-15**
D O'Hara, Lay Member	0	**5-10**	0	**0**	0	**0**	0	**0**	0	**0**	0	**5-10**

* These Governing Body members had pensionable remuneration from their CCG roles starting in 2014/15 which triggered a revaluation of previous NHS pension related benefits. ** The NHS Pensions Agency have advised that the higher figure for 2014/15 relates to the impact of both voluntary additional contributions and an in year salary increase.

5.2.2. Pension Benefits SUBJECT TO AUDIT

Name and title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2016	(h) Employer's contribution to stakeholder pension
	£000	£000	£000	£000	£000	£000	£000	£000
Dr N Balac, Chairman	0-2.5	2.5-5	10-15	40-45	243	21	267	0
LJ Smith, Chief Officer*	0	0	0	0	0	0	0	0
Dr M Ghani, Medical Director	2.5-5	2.5-5	10-15	30-35	129	26	157	0
B Reid, Chief Nurse	0-2.5	0-2.5	25-30	80-85	489	19	513	0
H Wells, Chief Finance Officer	0-2.5	0-2.5	45-50	25-30	299	14	317	0
V Peverelle, Chief of Corporate Affairs	0-2.5	2.5-5	25-30	80-85	463	34	502	0
Dr J Harban, Governing Body Member	0-2.5	0-2.5	5-10	25-30	185	7	195	0
Dr S Krishnasamy, Governing Body Member	0-2.5	0-2.5	5-10	20-25	89	1	91	0

* Member has opted not to join the NHS Pension Scheme

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

5.3. Compensation for early retirement or loss of office *SUBJECT TO AUDIT*

No payments have been made in compensation for early retirement or for loss of office.

5.4. Payments to past directors *SUBJECT TO AUDIT*

No payments have been made to past directors.

5.5. Pay Multiples *SUBJECT TO AUDIT*

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

The banded remuneration of the highest paid director/member in Barnsley CCG in the financial year 2015/16 was £135,000 (2014/15, £97,500). This was 4.7 times (2014/15, 3.4) the median remuneration of the workforce, which was £28,200 (2014/15, £28,900). This increase is due to one individual filling the post of Chief Officer reflecting full year costs.

In 2015/16 no (2014/15, nil) employees received remuneration in excess of the highest-paid director/member.

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

5.6. Staff report

Unless otherwise stated all the data below is for staff employed by Barnsley CCG on 31 March 2016.

5.6.1. Staff Numbers

As disclosed at Note 4.2 of the Accounts on average during the year the CCG employed 87 whole time equivalent (WTE) staff.

As at 31st March 2016 there were 120 staff employed by the CCG, as follows:

	Head Count	Whole Time Equivalents
Governing Body*	13	7.26
Other staff	107	79.84
Total**	120	87.1

* In addition three members of the Governing Body were paid 'off payroll' (see 5.6.6) and are therefore not included in the staff numbers above.

** The total includes 16 staff who TUPE transferred to Barnsley Healthcare Federation on 1 April 2016.

5.6.2. Staff composition

As at 31st March 2016 the composition of the CCG's workforce was as follows:

	Female	Male	Total
Governing Body*	6	10	16
Senior Managers**	21	7	28
Other Staff	72	7	79
Total	98	22	123

*The 3 members of the Governing Body who were paid 'off payroll' are included in the above
** The definition of senior managers was agreed at Band 8A and above for the purposes of this data.

5.6.3. Sickness Absence Data

As disclosed at Note 4.3 to the accounts, during the 2015 calendar year our average annual sick days per whole time equivalent member of staff was 7.7 (5.1 in 2014).

5.6.4. Staff policies

Consultation and engagement with employees is a fundamental principle of good employment practice. We hold regular staff briefings open to all staff, and heads of service hold team meetings with their teams. Staff are engaged through their team meetings and open staff briefings on the strategic direction and delivery of the organisation, and in its performance. We welcome suggestions and ideas from all staff on how we can improve our performance as an organisation.

We participated in the national NHS Staff Survey and we engage with Staff Side representatives on relevant matters. All policies are reviewed by the Equality Steering Group, which meets on a quarterly basis.

NHS Barnsley CCG is committed to supporting employees in the workplace. We have been awarded the Two Ticks disability symbol to encourage applicants from disabled people.

We have an Equal Opportunities Policy and a Flexible Working Policy which both support us to make reasonable adaptations to support our disabled employees. We have asked all staff for their disability status so that we may target support and development opportunities appropriately. An Equality Report is produced every year

which further refers to our equality practices and is available on our website www.barnsleyccg.nhs.uk

5.6.5. Consultancy expenditure

Consultancy expenditure is the provision to management of objective advice and assistance relating to strategy, structure, management or operations of an organisation in pursuit of its purposes and objectives. Such assistance will be provided outside the "business as usual" (BAU) environment when in-house skills are not available and will be of no essential consequence and time-limited. Services may include the identification of options with recommendations and/or assistance with (but not delivery of) the implementation of solutions.

During 2015/16 the CCG spent around £190k (2014/15 £259k) on consultancy services; the major schemes are identified below:

Community Nursing Review	£21k
CCG contribution to the South Yorkshire and Bassetlaw Sustainable Transformation Plan	£34k
Accountable Care Organisation development plan	£61k
CCG estates review	£15k
System leadership pioneer review.	£22k

5.6.6. 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 2016, for more than £220 per day and that last longer than six months are as follows:

	Number
Number of existing engagements as of 31 March 2016	3
Of which, the number that have existed:	
• For less than one year at the time of reporting	2
• For between one and two years at the time of reporting	0
• For between two and three years at the time of reporting	0
• For between three and four years at the time of reporting	1
• For four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2016	**3**

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.

The arrangement that has existed for between three and four 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 2015 and 31 March 2016	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:	
• Assurance has been received	2
• Assurance has not been received	0
• Engagements terminated as a result of assurance not being received	0

Both engagements are GPs on the Governing Body who have opted to be paid via their Practice, rather than the CCG's payroll.

Off payroll engagements of Governing Body Members with significant financial responsibility between 1 April 2015 and 31 March 2016 are as follows:

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	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. All three were paid through the payroll throughout 2015/16.

5.6.7. Exit packages and non-contractual payments ***SUBJECT TO AUDIT***

The following table details the exit packages made this year.

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Whole numbers	£s	Whole numbers	£s	Whole numbers	£s	Whole numbers	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	3	64,309	0	0	0	0	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	2	152,189	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0

6. Signature of the Accountability Report by the Accountable Officer

Lesley Smith
Accountable Officer
26 May 2016

SECTION 3

Financial Statements & Notes

FOREWORD TO THE ACCOUNTS

BARNSLEY CLINICAL COMMISSIONING GROUP

These accounts for the year ended 31 March 2016 have been prepared by the Barnsley Clinical Commissioning 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 2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	**5,013**	3,941
Operating Expenses	5	**401,053**	354,761
Other operating revenue	2	**(1,018)**	(581)
Net operating expenditure before interest		**405,048**	358,121
Investment Revenue	8	**0**	0
Other (gains)/losses	9	**0**	0
Finance costs	10	**0**	0
Net operating expenditure for the financial year		**405,048**	358,121
Net (gain)/loss on transfers by absorption	11	**0**	0
Total Net Expenditure for the year		**405,048**	358,121
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	**3,047**	3,074
Operating Expenses	5	**2,509**	2,990
Other operating revenue	2	**(269)**	(299)
Net administration costs before interest		**5,287**	5,765
Programme Income and Expenditure			
Employee benefits	4.1.1	**1,966**	867
Operating Expenses	5	**398,544**	351,771
Other operating revenue	2	**(749)**	(282)
Net programme expenditure before interest		**399,761**	352,356

Other Comprehensive Net Expenditure		2015-16 £000	2014-15 £000
Impairments and reversals	22	**0**	0
Net gain/(loss) on revaluation of property, plant & equipment		**0**	0
Net gain/(loss) on revaluation of intangibles		**0**	0
Net gain/(loss) on revaluation of financial assets		**0**	0
Movements in other reserves		**0**	0
Net gain/(loss) on available for sale financial assets		**0**	0
Net gain/(loss) on assets held for sale		**0**	0
Net actuarial gain/(loss) on pension schemes		**0**	0
Share of (profit)/loss of associates and joint ventures		**0**	0
Reclassification Adjustments			
On disposal of available for sale financial assets		**0**	0
Total comprehensive net expenditure for the year		**405,048**	358,121

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

Statement of Financial Position as at 31 March 2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	13	62	198
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		62	198
Current assets:			
Inventories	16	0	0
Trade and other receivables	17	3,301	1,915
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	80	90
Total current assets		3,381	2,005
Non-current assets held for sale	21	0	0
Total current assets		3,381	2,005
Total assets		3,443	2,203
Current liabilities			
Trade and other payables	23	(23,182)	(19,895)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total current liabilities		(23,182)	(19,895)
Non-Current Assets plus/less Net Current Assets/Liabilities		(19,739)	(17,692)
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		(19,739)	(17,692)
Financed by Taxpayers' Equity			
General fund		(19,739)	(17,692)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		(19,739)	(17,692)

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

The financial statements on pages 1 to 4 were approved by the Governing Body on 26th May 2016 and signed on its behalf by

Chief Officer / Accountable Officer
26th May 2016

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(17,692)	0	0	(17,692)
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	(17,692)	0	0	(17,692)
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(405,048)			(405,048)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	0	0	0	0
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(405,048)	0	0	(405,048)
Net funding	403,001	0	0	403,001
Balance at 31 March 2016	(19,739)	0	0	(19,739)

	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 of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	0	0
Adjusted NHS Commissioning Group balance at 1 April 2014	(15,151)	0	0	(15,151)
Changes in NHS Commissioning Group taxpayers' equity for 2014-15				
Net operating costs for the financial year	(358,121)			(358,121)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	0	0	0	0
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Commissioning 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)

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

Statement of Cash Flows for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(405,048)	(358,121)
Depreciation and amortisation	5	136	296
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	(1,386)	186
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	3,287	1,950
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		(403,011)	(355,689)
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		(403,011)	(355,689)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		403,001	355,580
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		403,001	355,580
Net Increase (Decrease) in Cash & Cash Equivalents	20	(10)	(109)
Cash & Cash Equivalents at the Beginning of the Financial Year		90	199
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		80	90

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

Notes to the financial statements

Note 1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups (CCGs) shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to CCGs, 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 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 CCG 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 CCG has entered into- pooled budget arrangements under Section 75 of the National Health Service Act 2006 for activities relating to Children's Services and the Better Care Fund. A memorandum note to the accounts provides details of the joint income and expenditure (note 35, Page 31).

The Children's Services pool is hosted by Barnsley Metropolitan Borough Council; the Better Care Fund operates on an aligned budget basis. The CCG makes contributions to the pools, which are then used to purchase healthcare services. The CCG accounts for its share of assets, liabilities, income and expenditure of the pools as determined by the pooled budget agreement.

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 substantially 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 CCG's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

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 Chief Finance Officer; the key accruals being healthcare contracts and prescribing were reported to the Audit Committee of Barnsley CCG.

Notes to the financial statements

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 CCG 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 CCG 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 CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

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 CCG;
- 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 valuation.

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

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

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

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

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

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

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

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.

Notes to the financial statements

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 CCG'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 CCG;
- Where the cost of the asset can be measured reliably; and,
- Where the cost is at least £5,000.

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

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

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

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 CCG expects to obtain economic benefits or service potential from the asset. This is specific to the CCG 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 CCG 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 1.16 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.

Notes to the financial statements

Note 1.17.1 The CCG 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 CCG'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 CCG as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the CCG'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 CCG'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 1.18 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 CCG 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 CCG'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 CCG'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 CCG 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 CCG's Statement of Financial Position.

Note 1.18.6 Other Assets Contributed by the CCG to the Operator

Assets contributed (e.g. cash payments, surplus property) by the CCG 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 CCG, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Note 1.19 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 CCG's cash management.

Notes to the financial statements

Note 1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

Note 1.23 Non-clinical Risk Pooling

The CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the CCG 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 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the CCG contributes annually to a pooled fund, which is used to settle the claims.

Note 1.25 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the CCG 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 1.26 Contingencies

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

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

Notes to the financial statements

Note 1.27 Financial Assets

Financial assets are recognised when the CCG 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 1.27.1 Financial Assets at Fair Value Through Profit and Loss

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

Note 1.27.2 Held to Maturity Assets

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

Note 1.27.3 Available For Sale Financial Assets

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

Note 1.27.4 Loans & Receivables

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

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

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

At the end of the reporting period, the CCG 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 1.28 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the CCG 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 1.28.1 Financial Guarantee Contract Liabilities

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

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

Note 1.28.2 Financial Liabilities at Fair Value Through Profit and Loss

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

Note 1.28.3 Other Financial Liabilities

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

Note 1.29 Value Added Tax

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

Notes to the financial statements

Note 1.30 Foreign Currencies

The CCG'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 CCG's surplus/deficit in the period in which they arise.

Note 1.31 Third Party Assets

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

Note 1.32 Losses & Special Payments

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

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

Note 1.33 Subsidiaries

Material entities over which the CCG 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 CCG 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 1.34 Associates

Material entities over which the CCG has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the CCG's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the CCG's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the CCG 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 1.35 Joint Ventures

Material entities over which the CCG 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 1.36 Joint Operations

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

Note 1.37 Research & Development

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

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

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

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

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

Note 2. Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	623	269	354	291
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	0	0	0	31
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	48	0	48	80
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	347	0	347	179
Total other operating revenue	1,018	269	749	581

Within the above are the recovery of costs incurred by the CCG on behalf of Barnsley Healthcare Federation (Community Interest Company).

During 2015/16 the CCG incurred £230,000 of pay costs and £170,000 of non pay costs which were recharged to the new organisation. These recharges are recorded as revenue within Recoveries in respect of employee benefits and Other revenue respectively.

Note 3. Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	1,018	269	749	581
From sale of goods	0	0	0	0
Total	1,018	269	749	581

Note 4. Employee benefits and staff numbers

Note 4.1.1 Employee benefits

2015-16	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	4,084	3,419	665	2,355	2,268	87	1,729	1,151	578
Social security costs	299	299	0	201	201	0	98	98	0
Employer Contributions to NHS Pension scheme	414	414	0	275	275	0	139	139	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	216	216	0	216	216	0	0	0	0
Gross employee benefits expenditure	5,013	4,348	665	3,047	2,960	87	1,966	1,388	578
Less recoveries in respect of employee benefits (note 4.1.2)	(623)	(623)	0	(269)	(269)	0	(354)	(354)	0
Total - Net admin employee benefits including capitalised costs	4,390	3,725	665	2,778	2,691	87	1,612	1,034	578
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	4,390	3,725	665	2,778	2,691	87	1,612	1,034	578

Note 4.1.1 Employee benefits

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

Note 4.1.2 Recoveries in respect of employee benefits

	2015-16			2014-15
	Total £000	Permanent Employees £000	Other £000	Total £000
Employee Benefits - Revenue				
Salaries and wages	(587)	(587)	0	(247)
Social security costs	(15)	(15)	0	(19)
Employer contributions to the NHS Pension Scheme	(21)	(21)	0	(25)
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	(623)	(623)	0	(291)

Note 4.2 Average number of people employed

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	87	81	6	69
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

	2015-16 Number	2014-15 Number
Total Days Lost	1026	325
Total Staff Years	133	64
Average working Days Lost	7.7	5.1

Staff sickness absence is calculated with reference to the period 1st January 2015 to 31st December 2015.

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	0
	£000	£000
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme

Note 4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	3	64,309	0	0	3	64,309
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	2	152,189	0	0	2	152,189
£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	5	216,498	0	0	5	216,498

	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

	2015-16 Departures where special payments have been made		2014-15 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	0	0	0	0

Analysis of Other Agreed Departures

	2015-16 Other agreed departures		2014-15 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	0	0	0	0

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.
Redundancy and other departure costs have been paid in accordance with the provisions of the agenda for change terms and conditions (section 16) and the CCG's organisational change policy.

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.

There have been no non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report, where applicable.

Note 4.5 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as at 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.
The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.
The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

For 2015-16, employers' contributions of £436,756 were payable to the NHS Pensions Scheme (2014-15: £383,272) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014.

Note 5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	4,420	2,454	1,966	3,372
Executive governing body members	593	593	0	569
Total gross employee benefits	5,013	3,047	1,966	3,941
Other costs				
Services from other CCGs and NHS England	2,400	1,109	1,291	3,259
Services from foundation trusts	244,037	0	244,037	247,225
Services from other NHS trusts	13,689	52	13,637	13,769
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies*	47,474	0	47,474	34,337
Chair and Non Executive Members	387	387	0	381
Supplies and services – clinical	651	0	651	492
Supplies and services – general**	3,440	307	3,133	947
Consultancy services	189	3	186	259
Establishment	2,024	262	1,762	1,433
Transport	11	10	1	5
Premises	1,385	118	1,267	878
Impairments and reversals of receivables	19	19	0	0
Inventories written down	0	0	0	0
Depreciation	136	22	114	296
Amortisation	0	0	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
- Assets carried at amortised cost	0	0	0	0
- Assets carried at cost	0	0	0	0
- Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	68	68	0	90
Other non statutory audit expenditure				
- Internal audit services	0	0	0	0
- Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	48,405	0	48,405	46,027
Pharmaceutical services	581	0	581	586
General ophthalmic services***	122	0	122	22
General/Personal/Alternative Provider medical services	33,436	0	33,436	4,094
Other professional fees excl. audit	54	42	12	73
Grants to other public bodies	0	0	0	0
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	24	24	0	0
Education and training	186	86	100	78
Change in discount rate	0	0	0	0
Provisions	0	0	0	0
Funding to group bodies		0	0	0
CHC Risk Pool contributions	2,335	0	2,335	510
Other expenditure	0	0	0	0
Total other costs	401,053	2,509	398,544	354,761
Total operating expenses	406,066	5,556	400,510	358,702

* Within the 2015/16 figure are payments of £8.9 million to Barnsley Metropolitan Borough Council (BMBC) for contributions to the Better Care Fund pooled budget. A further £5.6 million has been invested with BMBC to support system resilience and 7 day services projects to create extra capacity and to deliver care in the most appropriate setting to manage system-wide pressures.

** Within the 2015/16 figure are payments to the Barnsley Healthcare Federation (Community Interest Company) relating to the Prime Ministers Challenge Fund (PMCF) Initiative which total £2.3 million. See also note 37.1.

*** Within the 2015/16 figure is an investment of £100,000 in the Primary Eye Care Assessment and Referral Service (PEARS).

Note 6.1 Better Payment Practice Code

Measure of compliance	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	8,801	55,935	8,167	42,427
Total Non-NHS Trade Invoices paid within target	8,725	55,633	7,985	42,107
Percentage of Non-NHS Trade invoices paid within target	**99.14%**	**99.46%**	**97.77%**	**99.25%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,392	264,809	2,413	267,132
Total NHS Trade Invoices Paid within target	2,381	264,419	2,381	266,910
Percentage of NHS Trade Invoices paid within target	**99.54%**	**99.85%**	**98.67%**	**99.92%**

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

Note 6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2015-16 £000	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	0	0

Note 7. Income Generation Activities

The CCG does not undertake any income generation activities.

Note 8. Investment revenue

	2015-16 £000	2014-15 £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

	2015-16 £000	2014-15 £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

	2015-16 £000	2014-15 £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**

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

The CCG had no functions transferredthat have given rise to a recognised gain or loss in 2015-16 (2014-15: nil).

Note 12. Operating Leases

Note 12.1 As lessee

Note 12.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense								
Minimum lease payments	0	756	2	758	0	759	2	761
Contingent rents	0	0	0	0	0	0	0	0
Sub-lease payments	0	0	0	0	0	0	0	0
Total	0	756	2	758	0	759	2	761

The amount recognised in note 12.1.1 under Buildings has been paid to NHS Property Services Ltd (£131k) and Community Health Partnership Ltd (£625k). The amount paid to NHS Property Services Ltd in this financial year relates to the occupancy of Hillder House (the CCG's Headquarters - £105k) and void space for Health centres that were transferred to the Lessor on the abolition of the PCT (£26k).

The remaining balance, £625k relates to Void, bookable and Subsidiary 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 Photocopier Leases held by the CCG.

Note 12.1.2 Future minimum lease payments

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payable:								
No later than one year	0	0	2	2	0	0	2	2
Between one and five years	0	0	2	2	0	0	4	4
After five years	0	0	0	0	0	0	0	0
Total	0	0	4	4	0	0	6	6

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

	2015-16 £000	2014-15 £000
Recognised as income		
Rent	0	0
Contingent rents	0	0
Total	0	0

Note 12.2.2 Future minimum rental value

	2015-16 £000	2014-15 £000
Receivable:		
No later than one year	0	2
Between one and five years	0	4
After five years	0	0
Total	0	6

Note 13 Property, plant and equipment

2015-16	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2015	0	0	0	0	0	0	642	237	879
Addition of assets under construction and payments on account									
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/Valuation At 31 March 2016	0	0	0	0	0	0	642	237	879
Depreciation 1 April 2015	0	0	0	0	0	0	444	237	681
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	136	0	136
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2016	0	0	0	0	0	0	580	237	817
Net Book Value at 31 March 2016	0	0	0	0	0	0	62	0	62
Purchased	0	0	0	0	0	0	62	0	62
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	0	0	0	0	0	0	62	0	62
Asset financing:									
Owned	0	0	0	0	0	0	62	0	62
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	0	0	0	0	0	0	62	0	62

Revaluation Reserve Balance for Property, Plant & Equipment

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Balance at 1 April 2015	0	0	0	0	0	0	0	0	0
Revaluation gains	0	0	0	0	0	0	0	0	0
Impairments	0	0	0	0	0	0	0	0	0
Release to general fund	0	0	0	0	0	0	0	0	0
Other movements	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	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 2016 (31 March 2015: nil)

Note 13.2 Donated assets
The CCG has no donated assets as at 31 March 2016 (31 March 2015: nil)

Note 13.3 Government granted assets
The CCG has no Government granted assets as at 31 March 2016 (31 March 2015: 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 2015-16 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 2015: 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 2015: nil).

Note 13.7 Temporarily idle assets
The CCG has no temporarily idle assets as at 31 March 2016 (31 March 2015: 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 2016 (31 March 2015: 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	0	2
Furniture & fittings	0	0

Note 14. Intangible non-current assets

2015-16	Computer Software: Purchased £000	Computer Software: Internally Generated £000	Licences & Trademarks £000	Patents £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 1 April 2015	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 at 31 March 2016	0	0	0	0	0	0
Amortisation at 1 April 2015	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 2016	0	0	0	0	0	0
Net Book Value at 31 March 2016	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 2016	0	0	0	0	0	0

Revaluation Reserve Balance for intangible assets

	Computer Software: Purchased £000's	Computer Software: Internally Generated £000's	Licences & Trademarks £000's	Patents £000's	Development Expenditure (internally generated) £000's	Total £000's
Balance at 1 April 2015	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
At 31 March 2016	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 2016 (31 March 2015: nil).

Note 14.2 Government granted assets
The CCG has no Government granted assets as at 31 March 2016 (31 March 2015: nil).

Note 14.3 Revaluation
The CCG hold no intangible assets. For this reason no revaluation has taken place (31 March 2015: nil).

Note 14.4 Compensation from third parties
The CCG in 2015-16 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 2015: 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 2015: 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 2015: nil).

Note 14.7 Temporarily idle assets
The CCG has no temporarily idle assets as at 31 March 2016 (31 March 2015: 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 2016 (31 March 2015: 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 2016 (31 March 2015: nil).

Note 16. Inventories
The CCG has no inventories as at 31 March 2016 (31 March 2015: nil).

Note 17. Trade and other receivables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue*	1,890	0	355	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	863	0	1,356	0
NHS accrued income	6	0	0	0
Non-NHS receivables: Revenue	457	0	85	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	49	0	109	0
Non-NHS accrued income	15	0	0	0
Provision for the impairment of receivables	(19)	0	0	0
VAT	2	0	7	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	38	0	3	0
Total Trade & other receivables	3,301	0	1,915	0
Total current and non current	3,301		1,915	

* Included in the 2015/16 figure are provider contractual undertrades resulting in a receivable balance being recognised in the accounts. These undertrades will be recovered through a reconciliation exercise during 2016/17. The largest undertrade that has been recognised in the accounts is £1.4 million relating to Sheffield Teaching Hospitals NHS Foundation Trust.

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	2015-16 £000	2014-15 £000
By up to three months	445	379
By three to six months	0	41
By more than six months	40	20
Total	485	440

£5,624 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, 2016.

Note 17.2 Provision for impairment of receivables	2015-16 £000	2014-15 £000
Balance at 1 April 2015	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(19)	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2016	(19)	0

The impaired receivable represents a single receivable over six months old and is considered to be irrecoverable by the CCG.

Note 18. Other financial assets
The CCG has no other financial assets as at 31 March 2016 (31 March 2015: nil).

Note 19. Other current assets
The CCG has no other current assets as at 31 March 2016 (31 March 2015: nil).

Note 20. Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 1 April 2015	90	199
Net change in year	(10)	(109)
Balance at 31 March 2016	**80**	90
Made up of:		
Cash with the Government Banking Service	80	90
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	**80**	90
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2016	**80**	90
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 2016 (31 March 2015: nil).

Note 22. Analysis of impairments and reversals
The CCG has no impairments or reversals of impairments recognised in expenditure during 2015-16 (2014-15: nil).

Note 23. Trade and other payables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,315	0	837	0
NHS payables: capital	0	0	0	0
NHS accruals	2,103	0	3,734	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	7,629	0	2,503	0
Non-NHS payables: capital	0	0	0	0
Non-NHS accruals	11,557	0	10,139	0
Non-NHS deferred income	0	0	0	0
Social security costs	53	0	38	0
VAT	0	0	0	0
Tax	69	0	44	0
Payments received on account	0	0	0	0
Other payables	456	0	2,600	0
Total Trade & Other Payables	23,182	0	19,895	0
Total current and non-current	23,182		19,895	

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 2015: nil).

Other payables include £66,721 outstanding pension contributions at 31 March 2016 (31 March 2015: £58,642).

Note 24. Other financial liabilities
The CCG has no financial liabilities as at 31 March 2016 (31 March 2015: nil).

Note 25. Other liabilities
The CCG has no other liabilities as at 31 March 2016 (31 March 2015: nil).

Note 26. Borrowings
The CCG has no borrowings as at 31 March 2016 (31 March 2015: 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 2015-16 (2014-15: nil).

Note 28. Finance lease obligations
The CCG has no finance leases as at 31 March 2016 (31 March 2015: nil).

Note 28.1 Finance leases as lessee
The CCG has no future sublease payments expected to be received as at 31 March 2016 (31 March 2015: nil).

Note 29. Finance lease receivables
The CCG has no finance lease receivables as at 31 March 2016 (31 March 2015: nil).

Note 29.1 Finance leases as lessor
The CCG has no unguaranteed residual value accruing as at 31 March 2016 (31 March 2015: nil).

The CCG has no accumulated allowance for uncollectable lease receivables as at 31 March 2016 (31 March 2015: nil).

Note 29.2 Rental revenue

	2015-16 £000	2014-15 £000
Contingent rent	0	0
Other	0	0
Total	0	0

The CCG has no contingent rents recognised in expenditure during 2015-16 (2014-15: nil).

Note 30. Provisions
The CCG had no provisions as at 31 March 2016 (31 March 2015: 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 2016 is £3,956k. (31 March 2015: £5,568k).

Note 31. Contingencies

	2015-16 £000	2014-15 £000
Contingent liabilities		
Equal Pay	0	0
NHS Litigation Authority Legal Claims	0	0
Employment Tribunal	0	0
NHSLA employee liability claim	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 2016 (31 March 2015: 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 31 March 2016 (31 March 2015: 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 CCG in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the CCG Prime Financial Policies and other policies agreed by the Governing Body. 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 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' 2015-16 £000	Loans and Receivables 2015-16 £000	Available for Sale 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,896	0	1,896
· Non-NHS	0	472	0	472
Cash at bank and in hand	0	80	0	80
Other financial assets	0	38	0	38
Total at 31 March 2016	0	2,486	0	2,486

Note 33. Financial instruments continued

Note 33.2 Financial assets (continued)

	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 2016	0	533	0	532

Note 33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	Other 2015-16 £000	Total 2015-16 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,418	3,418
· Non-NHS	0	19,642	19,642
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	0	23,060	23,060

	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 2016	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.

	2015-16 £'000
Total Gross Expenditure (as per note 5, page 17)	406,066
Total Gross Income (as per note 2, page 12)	(1,018)
Total Net Expenditure as at 31 March 2016	405,048
Total Assets (as per Statement of financial position, page 2)	3,443
Total Liabilities (as per Statement of financial position, page 2)	(23,182)
Total Net Assets as at 31 March 2016	(19,739)

During the year, the CCG spent £399,761,000 on the commissioning of healthcare and other services, this represents 96.7% of the CCG's total available resource. 48.2% of our resources were transacted with the CCG's two main local providers: £125,873,000 (31.5%) to Barnsley Hospitals NHS Foundation Trust, and £66,919,000 (16.7%) to South West Yorkshire Partnership NHS Foundation Trust.

Note 35. Pooled budgets

Children and Young Peoples Trust
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:

	2015-16 £000	2014-15 £000
Contribution to pooled commissioning budget		
Opening Balance at 1 April 2015	0	0
Barnsley Clinical Commissioning Group	5,841	5,167
Barnsley Metropolitan Borough Council	24,568	26,841
	30,409	32,008
Services commissioned from pooled budgets		
Barnsley Metropolitan Borough Council	21,604	26,017
South West Yorkshire Partnership NHS Foundation Trust	7,607	5,139
Barnsley Clinical Commissioning Group	1,198	852
Over / (Under) spend	2,131	750
Transfer / Use of Balances	(2,131)	(750)
Total	30,409	32,008
Net Balance	0	0

The £2,131,000 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 £453,000 in its financial statements for 2015-16. This relates to the budgets the CCG has statutory obligations for. Barnsley Metropolitan Borough Council have recognised a charge of £2,584,000

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 was underpinned by a Section 75 agreement between the commissioners. Governance arrangements are in place through the Barnsley Health and Wellbeing Board and the Board signed-off a plan for 2015/16. The CCG hosted this pooled arrangement during the 2015/16 financial year.

A summary of the pooled budget is shown below:

	2015-16 £000
Contribution to pooled commissioning budget	
Opening Balance at 1 April 2015	0
Barnsley Clinical Commissioning Group	17,370
Barnsley Metropolitan Borough Council	1,028
	18,398
Services commissioned from pooled budgets	
Barnsley Clinical Commissioning Group	10,529
Barnsley Metropolitan Borough Council	7,869
Total	18,398
Net Balance	0

The Better Care Fund arrangement contains an element of funding relating to achievement of reducing non elective admissions. During 2015/16 achievement was not met and this element of funding has been removed from the pool and distributed between the CCG and BMBC as per the risk sharing agreement. The value of achievement was £1,976,000 and was distributed equally.

Note 36. NHS LIft Investments
The CCG has no NHS LIFT investments as at 31 March 2016 (31 March 2015: nil).

Note 37. Related party transactions

The members of the Governing Body and key management staff who have had related party transactions with the CCG in 2015-16 are listed below.

		Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
St Georges Medical Centre - Dr Balac (Governing Body Chair)	Practice Payments	1,048	0	0	0
White Rose Medical Centre - Dr Ghani (Medical Director)	Practice Payments	1,178	0	0	0
Dr Harban & Partners - Dr Harban (Governing Body Member)	Practice Payments	1,033	0	0	0
Royston Group Practice - Dr Krishnasamy (Governing Body Member)	Practice Payments	1,071	0	0	0
Dr Law & Partners - Dr Luscombe (Governing Body Member)	Practice Payments	1,645	0	0	0
Kingswell Surgery - Dr King (Governing Body Member)	Practice Payments	670	0	0	0
Victoria Medical Centre - Dr Smith (Governing Body Member)	Practice Payments	1,300	0	0	0
Grove Medical Practice - Dr Guntamukkala (Governing Body Member)	Practice Payments	665	0	0	0
Kakoty Practice - M Hoyle (Governing Body Member)	Practice Payments	973	0	0	0

The above payments to practices includes delegated Primary Care Co Commissioning arrangements which are contractual. This is new for 2015-16 and represents payments made under General/Personal/Alternative Provider medical services contracts.

Lesley Smith, Chief Officer for the CCG. A declaration has also been made in relation to being an associate with the following entities:

- St Anne's Community Services, Leeds (Board Member)
- South Yorkshire Cancer Strategy Group (Chair)
- Working Together, Living with and beyond Cancer Programme, (in conjunction with McMillan Cancer Support)

No Payments have been made to these entities in 2015-16.

Dr Nick Balac, Governing Body chair for the CCG. St Georges Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation.

Dr Mehrban Ghani, Medical Director for the CCG holds a position with SAAG Ltd. No payments have been made to this company in 2015-16. White Rose Medical Centre is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation.

Dr John Harban, Governing Body Member is a Director for Lundwood Surgical Services Ltd. No payments have been made to this company in 2015-16. Dr Harben & Partners is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation.

Dr Sudhagar Krishnasamy, Governing Body Member is a Director for SKSJ Medicals Limited. No payments have been made to this company in 2015/16. Royston Group Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation.

Dr Madhavi Guntamukkala, Governing Body Member. Grove Medical Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation.

Marie Hoyle, Governing Body Member, is a Director for Barnsley Enterprise for Living Well (CIC). No payments have been made to this organisation in 2015-16. The Kakoty Practice is a member of Barnsley Healthcare Federation, a Community Interest Company (CIC). See note 37.1 for details of transactions with this organisation

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 37.1 Barnsley Healthcare Federation (Community Interest Company)

The Barnsley Healthcare Federation (Community Interest Company) was set up during the course of 2015-16 to provide NHS primary care services to the population of Barnsley. The organisation is made up of a significant number of Barnsley's GP practices.

The governing body members mentioned above are related to practices that are part of the Barnsley Healthcare Federation (Community Interest Company).

During 2015-16 the CCG recognised income from the Community Interest Company for the recharge of £400,000 of expenditure as disclosed at note 2. The CCG also made various expenditure transactions amounting to £2,414,000, of which the majority related to the Prime Ministers Challenge Fund (PMCF). This funding was secured following a successful bid to the PMCF and allocated for the purposes of enhanced access to primary care services across Barnsley. The funding was transacted by allocation from NHS England to the CCG and subject to an Alternative Provider Medical Services Contract between the CCG and the Barnsley Healthcare Federation (Community Interest Company).

In addition, the CCG awarded an Alternative Provider Medical Services contract. This was to operate the Brierley Medical Practice. The value of this contract for the period 1st December 2015 to 31st March 2016 was £104,000.

Note 38. 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.

Note 39. Losses and special payments

Note 39.1 Losses

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

	Total Number of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000	Total Number of Cases 2014-15 Number	Total Value of Cases 2014-15 £'000
Administrative write-offs	1	19	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	1	19	0	0

Note 39.2 Special payments

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

Note 40. Third party assets

	2015-16 £'000	2014-15 £'000
Third party assets held by the CCG	0	0

Note 41. 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		2015-16 Target £'000	2015-16 Performance £'000	Duty Achieved	2014-15 Target £'000	2014-15 Performance £'000	Duty Achieved
223H (1)	Expenditure not to exceed income	413,328	405,048	Yes	368,602	358,121	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	413,328	405,048	Yes	368,602	358,121	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 resource use on specified matter(s) does not exceed the amount specified in Directions	407,432	399,761	Yes	361,817	352,356	Yes
223J (3)	Revenue administration resource use does not exceed the amount specified in Directions	5,896	5,287	Yes	6,785	5,765	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 42. Impact of IFRS

	2015-16 £'000	2014-15 £'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 43. Analysis of charitable reserves

	2015-16 £'000	2014-15 £'000
Unrestricted funds	0	0
Restricted funds	0	0
Endowment funds	0	0
Total	0	0

KPMG

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

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

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

Respective responsibilities of the Accountable Officer and auditor

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

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

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

Scope of the audit of the financial statements

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

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

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

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

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

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

Opinion on financial statements

In our opinion the financial statements:

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

Opinion on regularity

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

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion, the Governance Statement does not reflect compliance with guidance issued by the NHS Commissioning Board;
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

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

Certificate

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

John Graham Prentice FCCA MBA
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

Date: 26 May 2016