NHS
Fylde and Wyre
Clinical Commissioning Group

Annual Report and Accounts 2015/16

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A healthier future for our communities

Contents

Foreword

Welcome to our third Annual Report.

As one of 200+ clinical commissioning groups (CCGs) established in 2013 under the Health and Social Care Act 2012, our purpose is to commission (plan and buy) hospital and community services for the Fylde and Wyre population of 151,000. In 2015/16 we extended our role and now have delegated responsibility from NHS England to commission family doctor services for our population.

The public funding we received in 2015/16 was £238 million. We spent £231 million of this funding commissioning services and £3.1 million running the CCG. We also achieved a £4.1 million surplus in line with our financial requirement.

2015/16 has been a challenging but fulfilling year. Our main focus was the design and implementation with Fylde coast colleagues of three new models of care to improve the health and wellbeing of our population and make better use of our health and care resources. ***Extensive Care*** provides tailored community-based health and social care to some of our older patients with the most complex needs. ***Enhanced Primary Care*** is an improved level of clinical and social support through new Integrated Neighbourhood Team for patients with at least one long-condition. ***Episodic Care*** is designed to provide improved care for patients with minor health issues. Extensive care 'went live' in June 2015 in our Lytham, St Annes, Ansdell and Freckleton neighbourhood. Enhanced and Episodic services are planned to start in Spring 2016. These initiatives have involved considerable engagement with a wide range of partners and we are very appreciative of their commitment. Find out more about these new services on our website: www.fyldeandwyreccg.nhs.uk/new-models/

Our work on new models of care has been assisted considerably by:

- Being part of one of 14 'Vanguard' sites to test the 'multispecialty community provider' model in NHS England's Five Year Forward View. This recognition has provided us with additional expertise and funding.
- Developing a new 'GP Quality Contract' to support the implementation of new models of care and provide a better way of commissioning enhanced services from GP practices such as better access for patients and greater use of digital health opportunities.
- Four established neighbourhoods which are leading their own local health priorities and providing essential clinical expertise and 'test bed' opportunities for the new models. Fleetwood neighbourhood has won funding from the Prime Minister's Challenge Fund and implemented some innovative new services such as video consultations, weekend GP appointments. Kirkham and Wesham is implementing the Pharmacy First scheme and providing a new wound care service. Lytham, St Annes, Ansdell and Freckleton is the early adopter site for the first extensive care service and the provider of the new wound care service. Thornton, Poulton and Over-Wyre has launched a new care home service, run by nurses, to support vulnerable patients and prevent hospital admissions.
- Being part of the successful Lancashire 'test bed' bid with technology company Phillips to pilot the use of wearable technology and home sensors to monitor health so that people can live more independently.
- Being part of the bid team that successfully achieved 'Healthy New Town' status from the King's Fund for a new housing development at Whyndyke Farm, one of ten national schemes to promote healthy living among residents.

- Our extensive patient and public engagement programme. We have continued our programme of listening cafes, focus groups and new models of care roadshows in each neighbourhood. Feedback from our surveys of public perception has been very positive and given us useful insights to include in our ongoing work. Our Patient and Public Engagement Group is well supported by a wide range of partners. We launched our People's Panel and attracted significant interest from local residents keen to volunteer to provide feedback across a range of issues. The Panel has been active since June and has already provided much useful help to the CCG.
- A healthy financial position. We met all our financial targets in 2015/16 including a surplus which will assist the overall finances of the NHS locally.

Despite our successes, we remain concerned that our significant providers (hospitals, ambulances and community services) have not achieved all performance and quality targets. In part, this is a reflection of the general pressures on the NHS. We continue to work with our providers in a variety of ways, including additional investment, to enable them to achieve sustainable improvements in care for patients.

We are grateful to all our partners for working with us constructively and continuously on the shared aim of improving the health and wellbeing of the population of Fylde and Wyre. We are also grateful to our CCG members and staff for their commitment, enthusiasm, patience and good humour throughout the year.

Mary Dowling	**Dr Tony Naughton**	**Dr Tom Johnson**
Chair, Governing Body	**Clinical Chief Officer**	**Chair, Council of Members**

Performance Report

Overview

Purpose and role

NHS Fylde and Wyre Clinical Commissioning Group was authorised in April 2013 under the Health and Social Care Act 2012.

We are the organisation responsible for planning and buying – or 'commissioning' – hospital and community health services in the area to meet patients' needs.

We receive a set amount of money from the government each year (£238million for 2015/16). We are committed to spending this wisely to ensure the people living locally receive the best possible healthcare.

We have 20 member practices and serve a population of 151,000 people across approximately 320 sq km of coast and countryside. The majority live in the urban towns of Fleetwood, Kirkham, Lytham St Annes, Poulton-le-Fylde and Thornton, but a significant proportion live in rural villages.

To become a CCG we went through a rigorous assessment process, and were authorised by NHS England to operate without conditions. We have had quarterly assessments, and have continued to perform well and remain without conditions placed on us.

We are responsible for identifying the specific health needs of local people, and ensuring these needs are met.

Our main area of responsibility is to use our annual NHS budget to plan and commission the highest quality outcome based hospital and community health services to meet public and patient needs. We also work with other commissioners such as NHS England who commission primary care services (GP services, community dentistry, optometry and pharmacy services), specialised services and health services for the armed forces. Public Health England and Lancashire County Council commission public health and health improvement services. We work in partnership with these other commissioners, local authorities and the voluntary sector to ensure that all health services are joined-up and meet the needs of patients and their families.

Like all NHS organisations, we are facing some very significant challenges. These include more people living longer with complex health conditions, rising expectations and increasing costs. It is estimated nationally that there will be a funding gap of £30billion by 2021 if health services continue to be delivered in the same way as they are now. The NHS needs to change to meet these demands.

More details about the challenges and risks facing the CCG and our plans to address them can be found in the annual governance statement on page 28 and our 2030 Vision for Health and Care, which is available on our website: www.fyldeandwyreccg.nhs.uk/2030

The key issues and risks that could affect the entity in delivering its objectives

The identified CCG risks are monitored within a risk register and reviewed by risk owners every two months. The register is then updated and presented to a number of relevant groups and committees including the Audit Committee for scrutiny and challenge prior to being received by the Governing Body. Those risks to the CCG achieving its strategic objectives are reflected in the Governing Body Assurance Framework.

In the last 12 months the CCG has reduced the risk scores of a number of risks, through implementing actions to remove, reduce or control the risks. Areas of reduced risk have included achieving the targets for the NHS England Dashboard and achievement of the CCG's Quality Premium; assurance about independent health care providers including nursing homes; the assurance about the process for deprivation of liberty applications; assurance about the management of Individual Funding Requests and Continuing Health Care processes; effective use of resources and demonstrating value for money whilst delivering a significant change agenda; managing the impact of delivering commissioned new models of care; achieving the Winterbourne Concordat requirement to discharge long stay patients with learning disabilities into community settings.

The CCG has been implementing some improvements to the risk reporting processes through the second half of 2015/16, to ensure the Governing Body has full sight of and clarity about the risks to the organisation achieving its strategic objectives.

Further information on risk and risk management can be found in the annual governance statement on page 28.

Performance summary

The performance of our providers (hospitals, ambulance and community services) in terms of achieving national targets has not been as good as we would have wished, a reflection, in part of the general pressures on the NHS. We continue to work with all our providers to help them to achieve not just national targets, but sustainable improvements in quality of care and performance

Performance analysis

2015/16 New NHSE Quarterly Assurance Framework and Process

All CCGs are externally monitored by NHS England (NHSE) that uses a formal framework to ensure that we are meeting our ongoing responsibilities to patients and the public. A refreshed approach to the Assurance Framework was undertaken in 2015/16 to address the changes that have taken place since the CCG came into being.

The refreshed approach recognises and reflects the following changes:

- An NHS responding to more challenging performance and financial positions together with an evolving commissioning landscape.
- CCG requirement to understand and fulfil their obligations for digital interoperability
- Delegated authority for primary care commissioning

The refreshed framework strengthens the focus on a CCG track record and on-going performance in delivering improvements for patients but it continued to assess a CCG capability as well as ensuring its fitness to take on additional roles and responsibilities.

The framework focussed on the five components as per the table below:

Component	Assurance level
Well-led organisation	**Good**
Delegated functions	**Good**
Finance	**Good**
Performance	**Good**
Planning	**Good**

Table 1: CCG assurance

The assurance outcome categories have been changed to:

- **assured as outstanding** – when fully assured across all five components
- **assured as good** – where there are minor concerns but overall the CCG is well led and demonstrates good organisational capacity or is effectively managing a higher level of risk
- **limited assurance, requires improvement** – where there is more serious performance or financial challenges with a high level of risk
- **not assured** – where a CCG is failing or is at risk of failing to discharge its functions

A baseline assessment was undertaken by NHSE on the 23 October 2015 and the ratings assigned per component of the assessment framework are identified above in Table 1. The end of year annual assessment took place on the 6 May 2016. We are now awaiting formal notification following national and regional moderation anticipated at the end of June. This will give us assurance level per component and an overall CCG headline level.

Emergency Preparedness, Resilience and Response

In November 2015 NHSE required the CCG to make a self-assessment return regarding Emergency Preparedness, Resilience and Response (EPRR) Assurance 2015/16. Through this assessment the CCG identified evidence that it was demonstrating Substantial compliance against the EPRR Core Standards. In addition the NHS England EPRR Framework requires each NHS organisation to maintain a good standard of preparedness to respond safely and effectively to a full spectrum of

threats, hazards and disruptive events. The CCG aligned its improvement plan following discussion with and feedback from NHS England. In May 2016, the CCG will review its EPRR improvement plan, incorporating any learning from the Lancashire and NW challenges experienced in 2015such as recent flooding incidents.

Detailed performance analysis

In July 2015 the Governing Body was informed about the rationale for the proposed changes to metrics and performance measures for 2015/16, which needed to be included in the CCG Performance Dashboard and the proposed CCG reporting standards. Whilst the 2015/16 CCG Assurance Framework was awaited, planning guidance informed the proposed metrics. The Governing Body Dashboard was developed around the NHS Constitution commitments; Outcomes and Quality Indicators; Better Care Fund Indicators and Local Priorities (which includes the local Quality Premium indicator). A set of guidance notes (incorporated into the Reporting principles/standards); process notes and data source trackers were produced.

As a CCG we rate our performance against 44 NHS Constitution and quality indicators. We have performance concerns regarding nine NHS Constitution targets:

- **Referral to Treatment (RTT) times for non-urgent consultant led treatment**
  The CCG is achieving this target overall. In year breaches within specific providers are managed monthly with action plans.
- **Diagnosis waiting times**
  The CCG is achieving this target overall. In year breaches within specific providers are managed monthly with action plans.
- **62 Day Cancer Wait**
  The CCG is achieving this target overall. In year breaches within specific providers are managed monthly with action plans.
- **Cancer two-week wait for an outpatient appointment**
  The CCG is achieving this target overall. In year breaches within specific providers are managed monthly with action plans.
- **A&E four-hour wait**
  The CCG is failing to achieve this target. The winter period proved to be a particularly difficult period with high numbers of admissions. The CCG is working collaboratively with Fylde coast providers and partners to ease these pressures.
- **NWAS targets (including ambulance handovers)**
  Regionally and locally we are failing against targets for Red 1[1] and Red 2[2] response times. An increase in A&E activity is having an impact. Our main provider has introduced a 'corridor nurse' in A&E to achieve the best possible standard of care for all patients accessing the department by ambulance. Our ambulance liaison officer continues to support by attending regular bed meetings. We have also introduced two additional rapid response vehicles and our newly commissioned Falls Car has supported improved performance. There are a number of workstreams planned for 2016/17 to enhance patient flow and prevent this level of congestion within the A&E department. These include: development of the emergency village, development of ambulatory care pathways, reductions in length of stay, reduction in readmissions and bed reconfiguration.
- **Improving Access to Psychological Therapist (IAPT) recovery and access**
  Good progress has been made towards the target of 50% for recovery rates in Fylde and Wyre. There was however a dip in performance in January 2016 which was anticipated due to

[1] **Red 1 -** **Patient suffered cardiac arrest or stopped breathing.**

[2] **Red 2 -** **All other life threatening emergencies.**

IAPT team capacity being transferred to adult mental health crisis and community teams. An action plan to deliver the lost activity and minimise the negative impact against the target is in place and the CCG is on course to achieve the in-year target.

- **Estimated diagnosis rate for people with dementia**
  The CCG is achieving an improved trend in performance month on month however this may not be sufficient to achieve the 67% target by year end. This is predominantly due to a revised increased prevalence number at the beginning of the year for the CCG which has created a stretched position for the end of the year. If the national prevalence calculation remained consistent with last year then this target would have been achieved.

We also have some concerns regarding the following quality indicators:

- **Health Care Associated Infections**
  The CCG and local providers have breached the annual trajectory for CDIF and MRSA. Robust action plans are in place to address factors which can contribute to these acquired infections. A significant antibiotic awareness campaign has been launched in year and each case is reviewed in detail to identify root causes and learning which is shared across the health economy.
- **Mortality**
  Over the period of 2015/16 working jointly with Blackpool CCG, the CCG has continued to monitor closely the Summary Hospital-level Mortality Indicator (SHMI) which indicates the level of unexpected deaths as Blackpool Teaching Hospitals Trust has been identified as an outlier on SHMI. The CCGs completed a provider risk tool and NHSE has received assurance regarding the action plan to address mortality, through the Lancashire Quality Surveillance Group, including identification of which pathways of care are contributing most significantly to the concerns about mortality. Regular update reports are received by the CCG's Quality Improvement, Governance and Engagement Committee and Governing Body. Whilst Blackpool Teaching Hospitals Trust remains a national outlier there has been a small and gradual improvement in the SHMI data. Revisions to the Fylde Coast governance arrangements for monitoring and reporting the mortality position are being implemented and the CCG continues to work co-operatively across the health economy to continue to strive for improvements in mortality.

Financial performance

Financial Context

A key part of our strategy this year has again been to ensure service quality and financial sustainability. This is fundamental to the achievement of the CCG's 2030 Vision for Health and Care. We continue to control and prioritise our service expenditure and investments and make effective use of the resources available to the CCG to meet our strategic aims.

2015/16 has again been a challenging year to address all of the pressures and demands on the service whilst meeting the CCG's financial duties. However our responsibilities have been achieved in 2015/16 and the CCG enters 2016/17 in a sound financial position to continue to implement its longer term strategy for improved healthcare services for its population. The financial performance for 2015/16 is summarised below.

The CCG's five year financial strategy underpins how the resources available to the CCG will be utilised to achieve our future strategic aims and objectives whilst delivering our operational requirements.

Financial Achievement 2015/16

Throughout the financial year the CCG has reported on its achievement against meeting its key financial duties and delivery against its financial plans. We have been successful in meeting all of our financial duties and financial performance targets for 2015/16, the details of which can be found in note 42 to the accounts. Additionally the CCG has delivered in full its QIPP programme for 2015/16. NHS England has undertaken its own performance assessment of the CCG's financial standing throughout the financial year. No issues have arisen of any concern.

The combined financial duties and plans monitored over the year were to:

Maintain expenditure within the resources allocated and deliver a 1.85% surplus
Total resources allocated to the CCG for 2015/16 were £238.28million. Our performance against the resources allocated is outlined in table 2 below and contained within the accounts on page 1 and notes 2 and 5.

	Programme £000	Administration £000	Total £000
Gross operating expenses	231,299	3,245	**234,544**
Other operating revenue	325	8	**333**
Net operating expenses	**230,974**	**3,237**	**234,211**

Table 2: Our performance against allocated resources

Our expenditure was below our income level by £4.07million, which equates to a 1.85% surplus. This surplus complies with NHS business rules and will be available to use to fund plans in future years.

Maintain expenditure within a maximum cash drawdown limit
Cash has been contained within a maximum cash drawdown limit of £234.07million.

Ensure running costs are contained within the allocated £22.50 per head of population
The running cost allocation was £3.58million for the financial year; we spent £3.24million.

Ensure compliance with the Better Payment Practice Code
More than 99% of both NHS and non NHS invoices were paid by the CCG within 30 days. The CCG met the 95% target of payment within 30 days in terms of the value and number of invoices relating to suppliers during the course of the year by the introduction of a 'controlled environment for finance' which supported the controlled access to data allowing invoices to be paid promptly.

Not entering into all commitments recurrently – ensuring 1% of CCG spending is on approved non-recurrent projects and that sufficient contingent sums are maintained
We used £4.93million of our allocation against non-recurrent expenditures and started the year with £2million of contingency which we applied against financial pressures faced during the year. The bulk of the non-recurrent expenditure was applied against transformational change in the acute setting, property issues and increases in drugs costs.

Deliver QIPP efficiency savings targets
QIPP (quality, innovation, productivity and prevention) efficiency saving schemes of £3 million were delivered during the financial year.

Analysis of expenditure 2015/16

Our main areas of total net operating expenses are shown below:

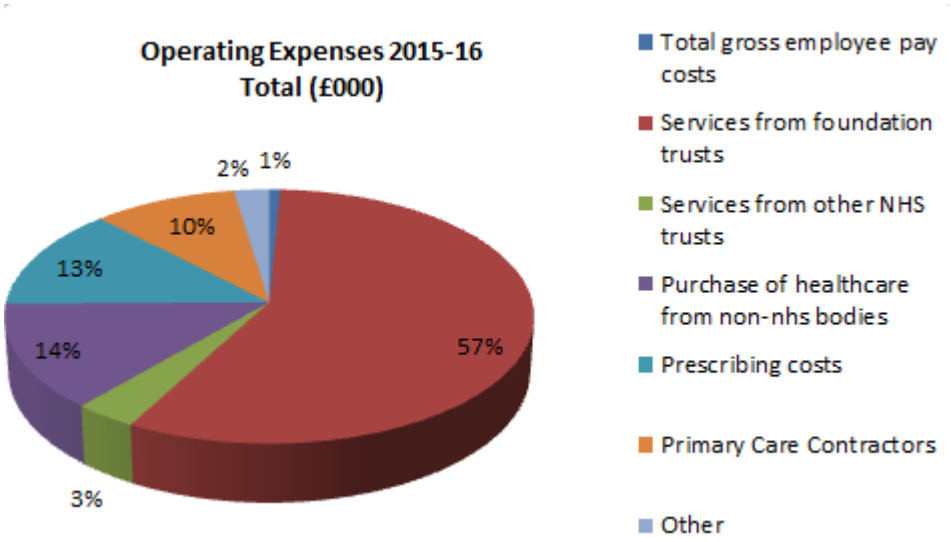

Figure 1: Main areas of total net operating expenses

Financial challenges 2015/16

We have faced a number of financial challenges during the year, to which we have positively responded. Particular focus of attention has been on:

- the risks associated with national policy implementation, local strategic plans and the significant transformational agenda being faced;
- the transformational challenge to ensure better utilisation of out of hospital services, whilst implementing the New Models of Care strategy;
- increasing financial pressure on budgets including secondary care access, continuing healthcare and prescribing; and
- Maintaining adequate and effective financial control and ensuring strong financial management, as well as delivering all financial duties including present and future QIPP efficiency savings targets.

The CCG's governance structure underpins the scrutiny, assurance, controls and reporting of the achievement of the CCG's financial duties and financial responsibilities. Risk to the achievement of these duties and responsibilities is robustly monitored and assured, with appropriate mitigation, through the CCG's committee structure. This includes reporting through to the Finance and Performance Committee, Audit Committee, and Remuneration Committee. The annual governance statement (page 28) gives further information on the risks and challenges we face and the control environment in which the CCG operates.

Future Financial Challenges

The CCG has commenced the implementation of its New Models of Care. This has been undertaken within the context of the Fylde Coast Vanguard arrangements and with the support of NHS England.

The CCG will be required to ensure that resources are available from 2016-17 onwards to ensure the achievement of its strategic and operational plans. There is a necessity to implement a significant QIPP programme from 2016-17 onwards of £3.8m to ensure financial sustainability.

The control and governance associated with these plans will be critical to ensure their achievement.

Dr Tony Naughton
Clinical Chief Officer
24 May 2016

Accountability Report

Corporate Governance Report

Members' Report

Member practices

The Council of Members represents all of our member practices. Voting members include the clinical chief officer of the CCG and a nominated clinical representative from each of the 20 GP practices that make up the CCG. The practice clinical representatives as at 31/3/16 are outlined in table 3 below.

Practice representative	Practice name	Address
Dr C Bolton*	Over Wyre Medical Centre	Wilkinson Way, Off Pilling Lane, Preesall, FY6 0FA
Dr R Thorpe	The Old Links Surgery	104 Highbury Road East, St Annes, FY8 2LY
Dr S Samad	Poplar House Surgery	24/26 St Annes Road East, St Annes, FY8 1UR
Dr S Adam*	Clifton Medical Practice	St Annes Health Centre, Durham Avenue, St Annes, FY8 2EP
Dr M Varia*	Park Medical Centre	St Annes Health Centre, Durham Avenue, St Annes, FY8 2EP
Dr J Reid	Ansdell Medical Centre	Albany Road, Lytham St Annes, FY8 4GW
Dr M Sloan*	Holland House	Lytham Primary Care Centre, Victoria Street, Lytham, FY8 5DZ
Dr S Ellwood	Fernbank Surgery	Lytham Primary Care Centre, Victoria Street, Lytham, FY8 5DZ
Dr A Janjua	Fleetwood Surgery	Fleetwood Surgery, West View Health Village, Fleetwood, FY7 8GU
Dr C Ramesh	Belle Vue Surgery	West View Health Village, Broadway, Fleetwood, FY7 GU
Dr F Guest	The Thornton Practice	Church Road, Thornton-Cleveleys, FY5 2TZ
Dr R Smyth	Broadway Medical Centre	West View Health Village, Broadway, Fleetwood, FY7 GU
Dr H Grenier	The Mount View Practice	London Street Medical Centre, London Street, Fleetwood, FY7 6HD
Dr P Pandya	The Village Practice	Church Road, Thornton-Cleveleys, FY5 2TZ
Dr V G Chandrasekar	Beechwood Surgery	23 Beechwood Drive, Thornton-Cleveleys, FY5 5EJ
Dr F Guest*	Carleton Surgery	Castle Gardens Crescent, Carleton, FY6 7NJ
Dr I Kirkham	The Surgery	Lockwood Avenue, Poulton-Le-Fylde, FY6 7AB
Dr K Greenwood	Queensway Medical Centre	Queensway, Poulton-Le-Fylde, FY6 7ST
Dr M Chavali	Ash Tree House	Church Street, Kirkham, PR4 2SE
Dr S Hardwick	Kirkham Health Centre	Moor Street, Kirkham, PR4 2DL

Table 3: Council of Members' membership

Note: Dr Tony Naughton, the CCG's clinical chief officer, is not the Council of Members' representative for the Thornton Practice.

***Dr C Bolton took over as the representative for Over Wyre Medical Centre in September 2015 (from Dr J Chesworth)**
***Dr M Varia took over as the representative for Park Medical Practice in September 2015 (from Dr M Zaryckyi)**
***Dr S Adam took over as the representative for Clifton Medical Practice in October 2015 (from Dr P Benett)**
***Dr F Guest took over as the representative for the Carleton Surgery in December 2015 (from Dr M Cook)**
***Dr M Sloan took over as the representative for Holland House Surgery in January 2016 (from Dr N Lowe)**

Governing Body membership 2015/16

Name	Title
Ms M Dowling	Chair
Dr A Naughton	Clinical chief officer
Mr I Stoddart (up to 31/5/15) Mr A Harrison (from 10/8/15)	Chief finance officer Chief finance officer
Mrs J Aldridge	Chief nursing officer
Mr P Tinson	Chief operating officer
Mr P Olive	Lay member (governance)
Mr K Toole	Lay member (patient and public engagement)
Dr I Stewart	Secondary care doctor
Dr P Benett	GP elected clinical lead
Dr V G Chandrasekar	GP elected clinical lead
Dr K Greenwood	GP elected clinical lead
Dr A Janjua	GP elected clinical lead
Dr T Johnson	GP elected clinical lead
Dr J Reid	GP elected clinical lead
Dr J Panesar	GP elected clinical lead
Dr F Guest	GP elected clinical lead

Table 4: Governing Body membership

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

"So far as the member is aware, there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and that the member has taken all the steps that they ought to have taken as a member in order to make themself aware of any relevant information and to ensure that the clinical commissioning group's auditor is aware of that information."

Audit Committee membership 2015/16

Name	Title
Mr P Olive	Lay member and chair (governance)
Mr K Toole	Lay member (patient and public engagement)
Dr I Stewart	Secondary care doctor

Table 5: Audit Committee membership

External audit

The CCG's auditors are KPMG. The cost of delivery of the work performed by the auditor for the 2015/16 accounting period was £54,000 (inc VAT). No other work was carried out by the external auditors during the year.

Declarations of interest

Declared interests for Governing Body members, Council of Members and CCG staff are available online at: www.fyldeandwyreccg.nhs.uk/declarations

Dr Tony Naughton
Clinical Chief Officer
24 May 2016

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 Medical Officer to be the Accountable Officer of the Clinical Commissioning Group.

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

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

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

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

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Dr Tony Naughton
Clinical Chief Officer
24th May 2016

Engagement

We have an active approach to patient and public engagement through our In Fylde and Wyre suite of engagement activities. This provides opportunities for our residents to contribute to commissioning decisions, service redesign and improvement in patient experience. Formal mechanisms include the following:

- Our Patient and Public Engagement Group (PPE) meets monthly and includes representation from Healthwatch, disadvantaged groups, the voluntary sector, disability representatives, carers and older people. The group's views are represented at the Quality Improvement, Governance and Engagement Committee, which reports to the Governing Body, and so is part of the CCG's official governance process.
- Patient participation groups (PPG) are GP practice-based patient groups. These meet regularly to discuss a range of local issues relating to primary care and support practices to carry out an annual patient survey and report. This enables a GP practice to develop an action plan to improve patient experience. A bi-monthly PPG chairs' group is coordinated by the CCG enabling patient groups to network and share good practice. A number of PPGs have also established local initiatives which contribute to the health and wellbeing of their community, for example dementia sing-a-longs and third sector information days.
- Our Influence membership scheme is open to individuals and organisations. Members receive regular updates and newsletters and are invited to the CCG's various events held throughout the year.
- We hold monthly People's Panel reviews. The People's Panel is based on a citizen's jury model with panel members providing feedback, views and suggestions on specific commissioning intentions.
- During 2015/16 we commissioned two engagement programmes targeting seldom heard groups, children and young people and lesbian, gay, bisexual and trans (LGBT+) communities. This will identify the experience of these groups in accessing primary care services and findings will help to build improvements in patient experience.
- Listening cafes are held regularly, giving people the opportunity to share their views and experience of NHS services. This allows the CCG to use soft data to monitor themes and trends in patient experience. These one-to-one, drop-in sessions also seek the views of local people in order to influence commissioning intentions.
- We hold regular information days for local residents and partner agencies through our roadshow programme. Events are held in each neighbourhood to enable people to contribute to our strategic development and to have their say in future service design. Our roadshow programme held in autumn 2015 focused on our New Models of Care and a number of suggestions and views have contributed to the development of our models.
- A number of sub groups exist where patients can share condition specific experiences. For example a cancer sub group has recently been formed to monitor the implementation of the Fylde Coast 5 year cancer strategy.

Following the roll out of the Friends and Family Test (FFT) in inpatient and A&E departments in April 2013, the CCG was successful in bidding to be a FFT pathfinder site contributing to NHS England guidance on implementation across a number of pathway touch points. The FFT became a contractual requirement for GP practices on 1 December 2014. The CCG reviews FFT data from provider services at its formal patient and public engagement group. The FFT data for GP practices is also reviewed at the patient participation group chairs meeting held bi-monthly. Data is triangulated with the national GP Patient survey and helps to inform individual practices' patient surveys and patient experience improvements.

The Fylde and Wyre Health and Wellbeing Partnership is chaired by the CCG's clinical chief officer, Dr Tony Naughton. This group consists of senior local authority and public health colleagues with representation from a range of statutory, voluntary and third sector organisations and has oversight of the wider health and wellbeing agenda.

The CCG also carries out regular 'deep dive' quality reviews of commissioned services. Patient engagement and participation is key to this process via focus groups to inform the direction of the reviews and by including patients, carers and their representatives in review visits.

We also attend a range of stakeholder partner events in order to maximise our opportunities for networking to enhance our knowledge of local support for patients, carers and their families.

In addition to this, the CCG holds regular focus groups to seek views on specific services and commissioning intentions. Examples of where patient insight has influenced service redesign include the Falls prevention pathway, the antibiotics awareness campaign, cancer strategy and new models of care. The CCG also undertakes regular surveys, and has recently completed its third representative telephone survey with Ipsos MORI to better understand people's preferences in order to inform the development of new care models, as well as its approach to choice communications.

Sustainability Report

We are required to report our progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure we comply with our obligations under the Climate Change Act 2008, including the adaptation reporting power, and the Public Services (Social Value) Act 2012.

We have a sustainable development management plan which sets out our commitments as a socially responsible employer. This features:

- compliance with environmental legislation;
- governance;
- organisational and workforce development;
- partnerships and networks;
- finance;
- energy and carbon management;
- commissioning and procurement;
- low carbon travel transport and access;
- water and waste; and
- designing building environment.

Key to delivery is working with other stakeholders such as NHS Property Services in areas where joint understanding and working is necessary.

The CCG recognises its responsibility towards sustainability and the many benefits it brings. Working closely with its partners and providers the CCG continues to support new ways of working and development that embrace the concept of sustainability. Any new projects either new build or refurbishment will include a sustainable package of measures that for example will include low energy lighting (LEDs) sustainable drainage solutions, heating controls and procurement of locally sourced materials and labour as standard and much more. Working closely with the CCG's landlord and health partners' encouragement will be given to the feasibility of "One Stop Health Provision" and the reduction in the need to make multiple trips to several locations in the same town. Travel plans will be explored to reduce car borne journeys and shared with stakeholders.

Such an approach has been undertaken with a new development in Poulton-le-Fylde to co-locate health and council services under one roof. The CCG will be investigating further opportunities for other services at this site. Continuing dialogue will be held with staff and providers. The CCG's estate strategy sets out the vision for the next few years ahead where sustainability will play a key role in all developments.

Equality Report

We believe that equality and diversity should be embedded into all of our commissioning activity. To ensure that we commission healthcare services to meet the needs of our diverse population, we are committed to involving local people in the continuing development and monitoring of our 2030 Vision. We are also committed to ensuring our staff and providers meet the equality duties as set out in the Equality Act 2010.

Moreover, we aim to provide equality of opportunity to all of our patients, their families and carers and to proactively eliminate direct or indirect discrimination of any kind.

This year we produced our second equality and inclusion annual report. This sets out how we have demonstrated due regard to the public sector equality duty's three aims. It also provides evidence for meeting the specific equality duty which requires all public sector organisations to publish their equality information annually.

Our equality and inclusion annual report has been published on our website: www.fyldeandwyreccg.nhs.uk. Hard copies are available upon request.

Our equality and inclusion strategy sets out our commitment to taking equality, diversity and human rights into account in everything we do – whether that is commissioning services, employing people, developing policies, communicating with and engaging local people in our work.

This strategy and associated action plan will help us to tackle health inequalities and promote equality and fairness in establishing a culture of inclusiveness. In these ways we will be able to build health services that meet the needs of all in Fylde and Wyre. Our Governing Body monitors our progress in achieving our ambitions and report regularly and openly on the developments in this plan.

We monitor our workforce and where employees are identified as having a disability or long-term condition as set out in the Equality Act 2010, access audits and reasonable adjustments are put in place to support them. We also carry out fair and equitable access to recruitment. This means that where an applicant indicates they have a disability or long-term condition as set out in the Equality Act 2010 reasonable adjustments are put in place.

We have embedded equality risk management into the equality analysis process, and have adopted an assessment toolkit which allows us to be assured of the risks associated with decision making in four areas: equality, privacy, human rights and quality. This therefore gives us an integrated approach to embedding equality into our core functions.

Workplace Race Equality Standard (WRES)

We are fully committed to inclusive workplaces that are free from discrimination – where all staff are able to thrive and flourish based on their diverse talent. This is evidenced through our organisational values - enacted through our behaviours at all levels, robust recruitment processes, support for team working and well-being in the workplace, and active awareness of equality and inclusion requirements embedded within our workplace practices.

Leadership of the Workplace Race Equality Standard is achieved through Governing Body level sponsorship and support of this work and is acknowledged as crucial in driving the changes forward. Successful equality, diversity and inclusion work, including work to implement the standard, requires specialist advice and support secured from Midlands and Lancashire Commissioning Support Unit, as well as the leadership which must come from Governing Body.

The Governing Body understands the principles of the Workplace Race Equality Standard and will ensure high level reporting of findings and learning is embedded across the CCG and enacted through our business processes to deliver measureable year on year improvements.

Remuneration Report

The Remuneration Report includes a number of items that are subject to the scrutiny of External Audit and some sections where External Audit is not required to give an opinion on the content. The items that are subject to audit are identified throughout the report.

There have been no awards made to past senior managers or directors. Nor have there been any payments made for loss of office or compensation on early retirement.

Salaries and allowances of the Governing Body 2015/16 (subject to audit)

Name	Title	Salary and fees (bands of £5000) £000	Taxable benefits (rounded to the nearest £00)	All Pension Related Benefits (bands of £2,500) £000	Total (bands of £5000) £000
Dr A Janjua	GP Clinical Lead/Vice chair	50-55	0	0	50-55
Dr K Greenwood	GP Clinical Lead	70-75	0	0	70-75
Dr J Reid	GP Clinical Lead	35-40	0	0	35-40
Dr T Johnson	GP Clinical Lead	40-45	0	0	40-45
Dr P Benett	GP Clinical Lead	55-60	0	0	55-60
Dr V G Chandrasekar	GP Clinical Lead	35-40	0	0	35-40
Dr J Panesar	GP Clinical Lead	40-45	0	0	40-45
Dr F Guest	GP Clinical Lead	35-40	0	0	35-40
Dr T Naughton	Clinical Chief officer	100-105	0	5-7.5	110-115
Mr A Harrison	Chief Finance Officer	65-70	0	22.5-25	90-95
Mr P Tinson	Chief Operating Officer	90-95	0	27.5-30	120-125
Mrs J Aldridge	Chief Nursing Officer	85-90	45	5-7.5	95-100
Ms M Dowling	Chair	25-30	0	0	25-30
Mr P Olive	Lay Member	10-15	0	0	10-15
Dr I Stewart	Secondary Care Doctor	10-15	0	0	10-15
Mr K Toole	Lay Member	5-10	0	0	5-10
Mr I Stoddart	Chief Finance Officer	15-20	3	5-7.5	20-25
Mr D Walsh	Interim Chief Finance Officer	55-60	0	0	55-60

Table 6: Salaries and allowances of the Governing Body 15/16

At the time of preparing the draft, no pension figures are available for Mr Andrew Harrison

Notes:

Mr A Harrison commenced his role on 10th August 2015.

Mr I Stoddart concluded his role on 31st May 2015.
Mr D Walsh acted as Interim Chief Finance Officer to cover the transition between Mr I Stoddart and Mr A Harrison, including a period of handover. Mr D Walsh was employed via agency and the full associated costs including VAT and agency charges are shown above.
Mr D Walsh's position on the Governing Body is also reflected in the number of off-payroll engagements of Governing Body members during the year disclosed on page 26 of this Annual Report.
The remuneration figures for Dr A Janjua, Dr T Johnson and Dr J Panesar includes one month's cost relating to 14/15 financial year (£3.3K for each party).

The CCG does not have a performance-related pay scheme; the performance of staff is measured through the CCG's appraisal process. There is therefore no reference to performance-related bonuses in table 6.

'All Pension Related Benefits' represents the annual increase in pension entitlements for the individual. The figures have been calculated in line with the HMRC method. This does not represent an actual payment made to an individual. Further details of Pension Benefits can be observed in table 8 which shows the annual increases in pension values in accordance with the NHS Business Services Authority guidelines.

Please note that the Department of Health has directed that calculations that result in negative figures are shown as zeros in the salaries and allowances disclosure notes.

The Secretary of State wrote on 2 June 2015 to Chairs of NHS Organisations about the pay of Very Senior Managers (VSMs). This included the introduction of controls on appointments of VSMs on salaries exceeding £142,500 per annum. Whilst table 6 does not identify any individuals with remuneration in excess of this value, it should be noted that the Chief Clinical Officer is paid on a part time basis and should the figure be shown as a full time equivalent it would represent £187,500.

Remuneration of the CCG Executive Team complies with the policies and guidance in place when remuneration levels were set. Remuneration in all cases is scrutinised and endorsed by Remuneration Committee (with specialist advice where necessary) and approved by Governing Body. The remuneration of the Chief Clinical Officer is in line with the pay review of clinicians undertaken in the North West when CCGs were established. The post holder is paid on a part time basis - it is not possible for him to work full time at the CCG as it is a requirement of the position to spend a proportion of time in practice.

Salaries and allowances of the Governing Body 2014/15

Name	Title	Salary and fees (bands of £5000)	Taxable benefits (rounded to the nearest £00)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5000)
		£000	£000	£000	£000
Dr A Janjua	GP Clinical Lead/Vice chair	45-50			45-50
Dr K Greenwood (c)	GP Clinical Lead	60-65			60-65
Dr J Reid	GP Clinical Lead	35-40			35-40
Dr T Johnson (d)	GP Clinical Lead	45-50			45-50
Dr P Benett	GP Clinical Lead	55-60			55-60
Dr V G Chandrasekar	GP Clinical Lead	35-40			35-40
Dr J Panesar (a)	GP Clinical Lead	20-25			20-25
Dr F Guest (b)	GP Clinical Lead	5-10			5-10
Dr T Naughton	Clinical Chief officer	105-110		302.5-305	405-415
Mr I Stoddart	Chief Finance Officer	95-100	2.6	7.5-10	110-115
Mr P Tinson	Chief Operating Officer	90-95		22.5-25	110-115
Mrs J Aldridge	Chief Nursing Officer	80-85	3.3	0	80-85
Ms M Dowling	Chair	25-30			25-30
Mr P Olive	Lay Member	10-15			10-15
Dr I Stewart	Secondary Care Doctor	10-15			10-15
Mr K Toole	Lay Member	5-10			5-10

Table 7: Salaries and allowances of the Governing Body 14/15

Notes:

Note (a) Dr J Panesar joined the Governing Body in September 2014.
Note (b) Dr F Guest's appointment was approved in September 2014 however she did not assume full duties until January 2015, following maternity leave.
Note (c) Dr K Greenwood's remuneration includes £16K relating to 13/14 financial year.
Note (d) Dr T Johnson's remuneration includes £3K relating to 13/14 financial year.

The CCG does not have a performance-related pay scheme; the performance of staff is measured through the CCG's appraisal process. There is therefore no reference to performance-related bonuses in table 7 above.

'All Pension Related Benefits' represents the annual increase in pension entitlements for the individual. The figures have been calculated in line with the HMRC method. This does not represent an actual payment made to an individual. Further details of Pension Benefits can be observed in table 8 which shows the annual increases in pension values in accordance with the NHS Business Services Authority guidelines.

Please note that the Department of Health has directed that calculations that result in negative figures are shown as zeros in the salaries and allowances disclosure notes.

Pension Entitlements – Senior Managers (subject to audit)

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015	Employer's contribution to partnership pension
		£000	£000	£000	£000	£000	£000	£000	£00
Dr T Naughton	Clinical Chief Officer	0-2.5	2.5-5	30-35	100-105	772	27	736	nil
Mr P Tinson	Chief Operating Officer	0-2.5	0-2.5	20-25	65-70	317	19	294	nil
Mr I Stoddart	Chief Finance Officer	0-2.5	0-2.5	35-40	105-110	643	4	609	nil
Mrs J Aldridge	Chief Nursing Officer	0-2.5	0-2.5	20-25	70-75	458	19	434	nil
Mr A Harrison	Chief Finance Officer	0-2.5	0-2.5	25-30	75-80	456	18	424	nil

Table 8: Pension entitlement of senior managers

Notes:

- **Figures provided for Dr Naughton are in respect of officer service only. On retirement the officer pension will be assessed by the superannuation fund against his other GP pensionable earnings to date and in the future.**
- **Not all members of the Governing Body are employees and therefore do not receive pensionable remuneration. As such there are no entries in respect of pensions for these individuals.**
- **Iain Stoddart left the CCG on 31st May 2015 and was replaced on a permanent basis by Andrew Harrison on 10th August 2015. The 'real increase' figures above have been adjusted to take this into account.**

Further to Department of Health guidance issued in 2015/16 in relation to Tax Arrangements of Off-Payroll Staff, it has been determined that GP Members of the Governing Body, as senior staff of the CCG, should be on the payroll of the organisation. These individuals should therefore be classified as employees of the organisation and their pension information identified in table 8. However during 2015/16 the GP Members of the Governing Body have been paid via off-payroll arrangements (as included in tables 10a to 10c). As such it is not possible to obtain the appropriate information to provide disclosures on the pensions of these individuals. Action is being taken by the CCG to address this issue for future reporting periods.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real Increase in CETV

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

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Pay multiples disclosure (subject to audit)

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

The banded remuneration of the highest paid member of the Governing Body in the financial year 2015/16 was £185,000-£190,000 (2014/15 was £185,000-£190,000). This was 4.58 times (2014/15 4.28 times) the median remuneration of the workforce, which was £40,964 (2014/15 £43,822).

In 2015/16, no employees received remuneration in excess of the highest paid member of the Governing Body (2014/15, zero).

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

There has been a small increase in the ratio observed between 14/15 and 15/16. The remuneration of the highest paid member of the Governing Body has remained constant however the composition of the workforce has changed in the year, showing a comparative increase in CCG employees with a lower cost to the organisation and therefore lowering the median pay figure.

Further disclosures on CCG staff costs can be seen at note 4 to the Annual Accounts.

Staff Report

The Staff Report includes a number of items that are subject to the scrutiny of External Audit and some sections where External Audit is not required to give an opinion on the content. The items that are subject to audit are identified throughout the report.

Senior Managers

The number of Senior Managers in the CCG, taken as at 31st March 2016, is shown below, both in terms of headcount (number) and whole time equivalent (WTE):

Pay Band	Number	WTE
VSM	1	0.6
9	3	3.0
8d	1	1.0
8c	4	3.75
TOTAL	**9**	**8.35**

Table 9a: Number of senior managers

For the purposes of this disclosure, the term 'Senior Managers' includes those staff at Executive Level and those managers who report directly to the members of the Executive Team.

Staff Categorisation

The following is an analysis of staff numbers, taken as at 31st March 2016, showing the categorisation of CCGs employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	Number	WTE
Medical Staff	2	1.0
Nursing Staff	9	9.0
Administration and Estates Staff	36	34.5
TOTAL	**47**	**44.5**

Table 9b: Staff categorisation

Note: the category definitions are consistent with those in the Information Centre's Occupational Code Manual. This may be observed via its website (www.ic.nhs.uk).

Staff Composition

The following is a breakdown of the staff numbers, 31st March 2016, identifying the gender of CCG employees both in terms of headcount (number) and whole time equivalent (WTE):

Category	Male		Female		TOTAL	
	Number	WTE	Number	WTE	Number	WTE
Senior Managers – Executive Team	3	2.6	1	1	4	3.6
Senior Managers – Other	0	0	5	4.8	5	4.8
Other CCG Employees	10	10	28	26.1	38	36.1
TOTAL	**13**	**12.6**	**34**	**31.9**	**47**	**44.5**

Table 9c: Staff composition

Staff Sickness Absence Data

Staff sickness absence and ill health retirement details can be found as part of the employee benefit disclosures in note 4 to the annual accounts.

Staff Policies

The CCG's employees are supported with a range of human resource policies, including flexible working, harassment and bullying at work and supporting attendance. The Equality and Diversity Policy promotes the active pursuit of equality and diversity through policies and ensures that employees receive fair, equitable and consistent treatment and that employees and potential employees are not subject to direct or indirect discrimination. The CCG systematically reviews its policies and procedures which are equality impact assessed and agreed by the Lancashire Partnership Forum which includes trade union representatives. These policies are then approved by the CCG's Remuneration Committee.

Expenditure on consultancy

The CCG has no spend on consultancy from 1 April 2015 to 31 March 2016 (2014/15 58K).

Remuneration Policy

The CCG's Remuneration Committee oversees and makes recommendations on the remuneration and conditions of service of the senior executive team taking into account any national or local guidance as appropriate. For 2015/16, the CCG's remuneration policy was to adhere to the national Agenda for Change pay award arrangements and apply them consistently to all executive and non-executive roles in the CCG. The CCG does not have a performance-related pay scheme; the performance of staff is reviewed through the CCG's appraisal process.

Off-payroll engagements (not subject to audit)

There 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 National Insurance arrangements.

Payments to GP practices for the services of GPs and employees are included in these disclosure requirements.

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016 - excluding payments in respect of GPs/Practice Staff	4
Number of existing arrangements as of 31 March 2016 – payments in respect of GPs/Practice Staff	10
Total Existing Arrangements	**14**
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	4
for between two and three years at the time of reporting	9

Table 10a: existing off-payroll arrangements

The individuals concerned are aware of the issue concerning assurance over tax obligations and have agreed to comply with HM Revenue and Customs requirements.

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	2
Number for whom assurance has been requested	1
Of which:	
Assurance has been received	1

Table 10b: New off-payroll arrangements

Off-payroll engagements regarding the Governing Body:

Number of off-payroll engagements of Governing Body members during the year.	9
Number of individuals that have been deemed Governing Body members during the financial year (this figure includes both off-payroll and on- payroll engagements).	18

Table 10c: Governing Body off-payroll numbers

Exit Packages

There have been no exit packages agreed between 1st April 2015 and 31st March 2016 (2014/15 nil).

Governance Statement

Introduction and context

The clinical commissioning group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2013, the CCG was licenced without conditions. The CCG was assessed against six authorisation domains:

- **Domain one**: a strong clinical and multi-professional focus which brings real added value.
- **Domain two**: meaningful engagement with patients, carers and their communities.
- **Domain three**: clear and credible plans which continue to deliver the quality innovation, productivity and prevention (QIPP) challenge within financial resources, in line with national requirements (including outcomes) and local joint health and wellbeing strategies.
- **Domain four**: proper constitutional and governance arrangements, with the capacity and capability to deliver all duties and responsibilities, including financial control, as well as effectively commission all the services for which it is responsible.
- **Domain five**: collaborative arrangements for commissioning with other CCGs, local authorities and NHS England as well as the appropriate external commissioning support.
- **Domain six**: great leaders who individually and collectively can make a real difference.

The CCG works with other commissioners, such as NHS England who support the commissioning of Primary Care services (GP services, community dentistry, optometry and pharmacy services), specialised services and health services for the armed forces. Public Health England and Lancashire County Council commission public health and health improvement services. The CCG works with these other commissioners, local authorities and the voluntary sector, locally, within the Fylde Coast economy and across Lancashire where appropriate, to ensure that all health and community based services are joined-up, integrated and meet the needs of our patients, public and their families. The CCG has an innovative and robust engagement programme which is essential to the achievement of all we strive to do.

The CCG maintains the highest levels of scrutiny, challenge, oversight and assurance to ensure statutory duties are met and public resources are used in the most effective and efficient way. We work closely with our auditors, Mersey Internal Audit Agency and KPMG, to ensure there is skilled and independent scrutiny on our actions, systems, procedures and controls. We have also sought additional scrutiny and assurance through a full Governing Body and Committee efficiency, effectiveness, evaluation and qualitative review.

The CCG has been assessed over the last three years by NHS England and has continued to perform effectively without any conditions being placed upon its operation. The CCG was assured as good across all five domains in its assurance assessment by NHS England in May 2015. The CCG is awaiting the results of the latest assessment which took place on 6 May 2016.

The CCG was recognised for its work and innovation in the 2015 Health Service Journal national awards, when it was one of six nationally to be shortlisted in the ‘CCG of the year’ category.

The CCG is in the midst of a very significant transformational service change agenda which supports its strategic 2030 vision, the need to maintain continuous service improvement and achieve quality focused outcomes for our patients and public. This is being driven by factors including rapidly evolving national policy, the development of New Models of Care to provide care closer to home, along with our role in the nationally sponsored Fylde Coast Vanguard and new delegated responsibilities for Primary Care Commissioning. To ensure we maintain our strategic and operational efficiency through this time of change we are joining up key strands of work, for example putting in place interdependent estates and IM&T strategies,

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, while 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 CC G Accountable Officer Appointment Letter.

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

Compliance with the Corporate Governance Code

While the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance with relevant principles of the Code is considered to be appropriate and good practice. This Annual Governance Statement is intended to demonstrate how the CCG has due regard to the principles set out in the Code and which are considered appropriate for CCGs.

The Clinical Commissioning Group 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 CCG

We have ensured that the CCG has been able to properly discharge its statutory functions, duties and responsibilities, with robust performance management processes and clear lines of accountability through well-established formal arrangements. We have has also had a clear focus on the future needs and requirements of our population.

The CCG's Constitution outlines the principles of good governance, which include observing the highest standards of propriety, impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business. It also sets out the roles and responsibilities of the Council of Members, Governing Body and the following CCG Committees:

- Audit Committee
- Remuneration Committee
- Quality Improvement, Governance and Engagement Committee
- Finance and Performance Committee
- Primary Care Commissioning Committee
- Clinical Commissioning Committee.

Assurance is provided to the Council of Members through the following structural and organisational control:

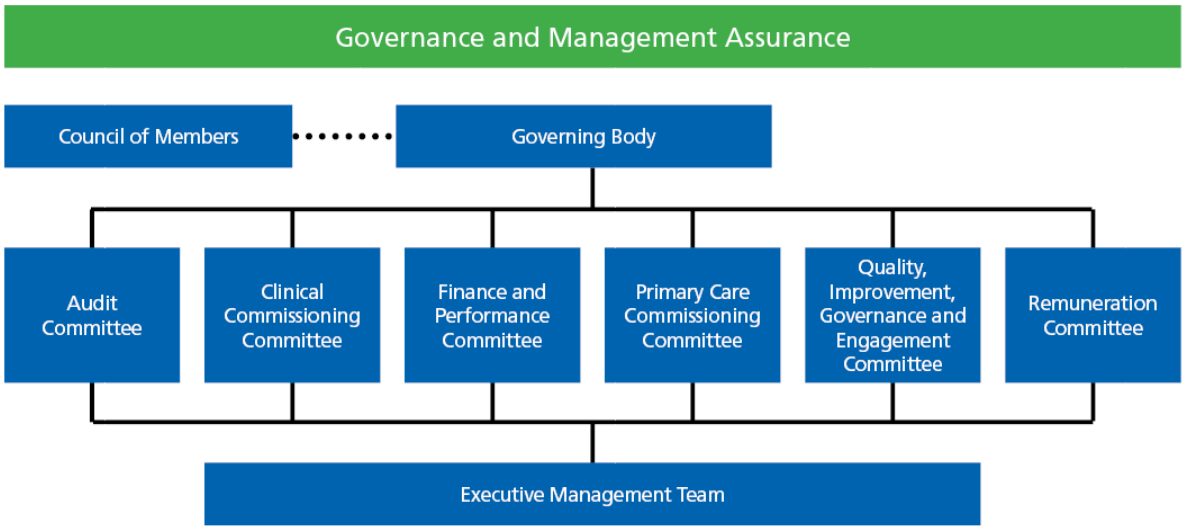

Figure 2: The CCG's structure

Council of Members

The Council of Members represents the 20 member practices of the CCG and is also responsible for representing the interests of the CCG as a whole. It meets monthly with executive officers present.

It has operated and contributed effectively throughout the period, with a clear focus on the CCG's strategic vision and its desired outcomes. The Council of Members has also had a significant focus on the future service and organisational form required to deliver service transformation, particularly the future development of out of hospital care and the development of our innovative neighbourhood vision. It is therefore vital we take a robust approach to conflicts of interest. We have refreshed our Conflicts of Interest policy during this reporting period and this has been assured by Mersey Internal Audit Agency. We have also reviewed our procedures for recording Declaration of Interests.

Alongside organisational issues and priorities, we ensure members have the opportunity to undertake personal and practice based development and this has included finance awareness and development sessions.

During the reporting period, the Council of Members has reviewed and is proposing amendments to the CCG's Constitution through NHS England as follows:

- Changes to the Governing Body Committee Terms of Reference and delegated powers as a result of a systematic CCG Committee effectiveness and efficiency review, supported and assured by Mersey Internal Audit Agency;
- Changes to delegated Primary Care Co-commissioning, collaborative and network arrangements;
- Amendments to the section on Conflicts of Interest in light of the new NHS England guidance; and
- Further small changes made to wording and statements following a review of the Constitution in line with the latest national policy requirements and guidance.

The Council of Members holds the Governing Body Members, both individually and collectively, to account for their performance on a monthly and annual basis through meetings and a robust appraisal process. In addition, they have positively influenced and informed the recommendations and decisions of the Governing Body's Clinical Commissioning Committee (its main service approval Committee) about commissioning and related plans to improve patient care and better use of resources.

The CCG has a clear focus on its responsibilities in the use of the public funds made available to it and of the necessity to always achieve the very best value for money outcomes possible.

Governing Body

The Governing Body is responsible for discharging the statutory duties and functions of the CCG.

Its role is to:

- Commission safe and effective community and secondary health care services on behalf of its population;
- Continually work towards the quality improvement of healthcare;
- Work in partnership with other CCGs and agencies to secure the overall health and wellbeing of the population; and
- Conduct business in accordance with its own Constitution, the NHS Constitution and other NHS statutory guidance.

It is responsible and accountable for delivering its financial duties, managing risk and for achieving national and local quality, productivity and service delivery targets.

The Governing Body meets in public bi-monthly and has also held development, education and discussions sessions throughout the year, covering issues including primary care commissioning and finance.

These protected time sessions allow members to continue to develop an in-depth understanding of key issues and the risks being faced and to enable them to appropriately drive the CCG's agenda forward and to make prompt and informed decisions. The formal agendas are set in accordance with the CCG's corporate objectives, its mission, aims and values, but remain flexible to accommodate our emerging and transformational work. We ensure that our agendas remain clinically, service and quality outcome focused and are truly engaging with our patients and public. A key focus of present and future agendas will undoubtedly be the continuing development and implementation of New Models of Care within this CCG and across the Fylde Coast.

It is my view that the Governing Body has operated effectively and efficiently throughout the reporting period, with the required attendance from all members to facilitate informed and appropriate decision making.

The Governing Body and all of the CCG committees undertake 'Self-Assessment Reviews' and report upon their duties, responsibilities and achievements against their agreed work plan on an annual basis.

The Governing Body has delegated responsibility for a range of functions to its committees, which are set out in the approved Terms of Reference of each Committee/Group and the CCG's Standing Orders and Scheme of Reservation and Delegation. The CCG's operational Scheme of Delegation has been regularly overseen by the Audit Committee, to ensure that it facilitates decision making, is 'fit for purpose' and that the robust and appropriate organisational and financial controls across the CCG and its evolving partnership arrangements especially are maintained.

Membership	May 15	Jul 15	Sept 15	Nov 15	Jan 16	Mar 16
Ms M Dowling, Chair	✓	✓	✓	✓	✓	✓
Dr A Naughton, Clinical Chief Officer	✓	✓	✓	✓	✓	
Mr I Stoddart(IS)/ Mr D Walsh(DW)/ Mr A Harrison (AH) Chief Finance Officer	✓ **(IS)**	✓ **(DW)**	✓ **(AH)**	✓ **(AH)**	✓ **(AH)**	✓ **(AH)**
Mrs J Aldridge, Chief Nursing Officer	✓	✓	✓	✓	✓	✓
Mr P Tinson, Chief Operating Officer	✓	✓	✓	✓	✓	✓
Mr P Olive, Lay Member, governance	✓		✓	✓	✓	✓
Mr K Toole, Lay Member, patient and public engagement	✓	✓	✓	✓	✓	✓
Dr I Stewart, secondary care doctor	✓	✓	✓	✓	✓	
Dr P Benett, GP elected clinical lead	✓		✓	✓	✓	✓
Dr VG Chandrasekar, GP elected clinical lead	✓	✓	✓	✓	✓	
Dr K Greenwood, GP elected clinical lead	✓	✓	✓	✓	✓	✓
Dr A Janjua, GP elected clinical lead	✓	✓	✓	✓	✓	✓
Dr T Johnson, GP elected clinical lead	✓		✓	✓	✓	✓
Dr J Reid, GP elected clinical lead	✓	✓	✓	✓	✓	✓
Dr J Panesar, GP elected clinical lead		✓	✓	✓	✓	✓
Dr F Guest, GP elected clinical lead	✓	✓		✓	✓	✓

Table 11: Governing Body attendance 2015/16

The Governing Body is quorate if five members are present, including at least one lay member, either the Clinical Chief Officer or the Chief Finance Officer and also at least three clinicians. The Governing Body has been quorate at each meeting during 2015/16.

Note: Iain Stoddart left the organisation on 31 May 2015 and was replaced by Andrew Harrison who commenced on 10 August 2016. David Walsh acted as interim Chief Finance Officer in the intervening period.

Governing Body GPs and lay members and executive officers are committed to supporting an effective performance culture and promote good governance, with sound controls across the

organisation. This is evidenced through the Governing Body's commitment to achieving the organisation's vision, culture and values, and the successful implementation of a range of strategic and operational objectives. These have been monitored and actively managed through ongoing performance management, reporting and actions, with the committees providing scrutiny, oversight and assurance Business intelligence, good communication and a rolling programme of leadership development within the CCG's organisation development plan have also supported the Governing Body.

Audit Committee

The Audit Committee is accountable to the Governing Body for providing an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG.

It comprises the following voting members:

- Lay Member responsible for governance;
- Lay Member responsible for patient and public engagement; and
- Secondary care doctor.

The Lay Member for governance chairs the committee and has a lead role in:

- Ensuring that the Council of Members and the Governing Body behaves with the utmost probity at all times;
- Providing assurance to the Governing Body on the robustness of the CCG's governance arrangements, including its system of internal control and on its corporate and clinical risk and financial management arrangements; and
- Ensuring that appropriate and effective whistleblowing and anti-fraud systems are in place. These particular systems remain under review and are being refreshed in light of latest policy and guidance.

The Lay Member for patient and public engagement provides an independent view of the work of the CCG. He helps to ensure that local people's voices are heard and that they have opportunities to be involved in the CCG's work. In particular he ensures that:

- Public and patients' views are heard and their expectations understood and met as appropriate; and
- The CCG has appropriate arrangements in place to secure public and patient involvement and responds in an effective and timely way to feedback and recommendations from patients, carers and the public.

The secondary care doctor brings to the discussions his understanding of patient care in the secondary care setting.

Other regular attendees are:

- the Chief Finance Officer;
- the Chief Nursing Officer
- Head of Finance;
- Internal Audit;
- Anti-Fraud Specialist; and
- External Audit.

The Audit Committee reviews:

- The effectiveness of the system of governance, risk management and internal control, incorporating the arrangements for the Council of Members; and
- The arrangements made by the CCG for managing conflicts of interest, whistleblowing and fraud (both clinical and non-clinical).

The Governing Body receives the minutes of the Audit Committee which cover the following issues:

- Governance, risk management and internal control: ensuring the establishment and maintenance of an effective system of governance and risk management across the CCG, including monitoring and reviewing the organisation's assurance framework and risk strategy and register;
- Internal audit: ensuring the audit function established is effective and meets the mandatory Public Sector Internal Audit Standards to provide appropriate assurance to the Governing Body. Ensuring internal audit reports finalised to date provide a positive assurance overview;
- External audit: ensuring the work and findings of the appointed External Auditors and considering the implications of the management responses to their work;
- Financial reporting: monitoring and delivery of the 2015/16 Annual Accounts timetable;
- Other assurance functions, including anti-fraud arrangements and reviewing anti-fraud work including whistleblowing;
- Conflicts of interest: ensuring that both actual and potential conflicts are managed in accordance and adherence with the CCG's conflicts of interest policy and national guidance. As referred to earlier in my statement this area of work is under on-going review in light of further best practice requirement and guidance

The Governing Body also receives a copy of the Audit Committee Annual Report.

Membership	21 Apr 2015	20 May 2015	1 Oct 2015	7 Jan 2016
Lay Member for Governance (Chair)	✓	✓	✓	✓
Lay Member for Patient and Public Engagement	✓	✓	✓	✓
Secondary Care doctor (Vice Chair)	✓		✓	✓

Table 12: Audit Committee membership attendance 2015/16

The Audit Committee meeting is quorate if a minimum of two voting members are present. The Audit Committee has been quorate at each meeting during 2015/16.

The Audit Committee formed part of the review of the CCG's Committee effectiveness and efficiency work and made recommendations and carried forward actions to proactively progress it to further enhance the CCG's strategic and operational performance. The Committee has also been very involved in their support and scrutiny of the national Annual Accounts month nine 2015/16 exercise and requirements, ensuring the CCG was well prepared for year end reporting and able to fully deliver its statutory duties and responsibilities. It also maintained active scrutiny of the use and reporting of national resources made available for the Fylde Coast economy Vanguard, with the full support and assurance of the CCG's Auditors.

Remuneration Committee

The Remuneration Committee makes recommendations to the Governing Body on the remuneration, fees and other allowances for employees and other persons providing services on behalf of the CCG.

It comprises the following voting members of the Governing Body:

- CCG Chair;
- Chair of the Council of Members;
- Lay Member for patient and public engagement;
- Lay Member responsible for governance; and
- Secondary care doctor.

The Remuneration Committee has been instrumental in ensuring that sound appraisal systems for all employees and the Governing Body on behalf of the Council of Members. Other non-voting attendees are invited to offer professional advice or services to the committee.

Membership	2 Jun 2015	30 Jun 2015	28 Jul 2015	29 Sep 2015	27 Oct 2015	22 Dec 2015	29 Mar 2016
Lay Chair of the Governing Body	✓	✓	✓	✓	✓	✓	✓
Lay Member for governance (Vice Chair)	✓	✓		✓	✓	✓	✓
Lay Member for Patient and Public Engagement	✓	✓	✓	✓	✓	✓	✓
Secondary Care doctor		✓	✓	✓	✓	✓	✓
Chair of the Council of Members	✓			✓	✓	✓	✓

Table 13: Remuneration Committee membership attendance 2015/16

The Remuneration Committee meeting is quorate if a minimum of three voting members are present, providing this includes either the Chair or the Vice Chair of the Committee. It has been quorate at each meeting during 2015/16.

The Committee has scrutinised and assured a review of the CCG's operational staffing structures. This aimed to ensure that the CCG had effective resources in place to carry out its functions and responsibilities as well as meeting the challenges and risks of transformational change.

The Remuneration Committee has prepared an annual report setting out the range of issues it has addressed in 2015/16.

Quality Improvement, Governance and Engagement Committee

The Quality Improvement, Governance and Engagement Committee provides assurance to the Governing Body and ensures effective, relevant and appropriate decisions are made in protecting the health and wellbeing of the population we serve. The Committee provides assurance that:

- Quality and patient engagement and involvement is integral to the work of the CCG;
- All the services that the CCG commissions are safe and effective and have been influenced by tangible public and patient engagement;
- There is continuous improvement in the quality of commissioned services, in primary medical services and in patient outcomes; and
- The principles of quality assurance and clinical governance are integral to the performance monitoring arrangements for all CCG commissioned services and are embedded within consultation, service development and redesign, evaluation of services and decommissioning of services.

It comprises the following voting Members or their nominated deputy:

- Chief Nursing Officer;
- Chief Operating Officer;
- Lay Member for patient and public engagement;
- Secondary care doctor;
- Elected Governing Body Clinical Lead for quality; and
- Elected Governing Body Clinical Lead for engagement, communications and partnerships.

The Committee has met monthly to provide assurance to the Governing Body on the development and implementation of the CCG's vision and strategy for continuous quality improvement. This has included performance management, service effectiveness, patient safety and experience and assurance of compliance with relevant regulatory standards. It has continued to pursue improvements in services provided to local people and has made a significant, continuing contribution to the combined efforts of the CCG and its partners to improve the quality of services at Blackpool Teaching Hospitals NHS Foundation Trust.

The Quality Improvement, Governance and Engagement Committee formed part of the review of Committee effectiveness and efficiency and its result of significant assurance.

Over the year, the Committee has approved a number of quality impact and risk assessments of commissioned services and advised on the development of a new tool to risk rate providers we commission, which will be implemented in 2016/17. This will complement the monthly primary care and other contracted providers' performance monitoring and the overall CCG risk register monitoring which has been undertaken by the committee in 2015/16.

Membership	May 15	Jun 15	Jul 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Chief Nursing Officer (Chair) or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Operating Officer or deputy	✓	✓		✓	✓	✓	✓	✓	✓	✓
Lay Member lead patient and public engagement	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Secondary care doctor	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Elected clinical lead: quality (Vice Chair) or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Elected clinical lead: engagement, communications and partnerships or deputy	✓	✓		✓	✓	✓	✓	✓	✓	✓

Table 14: Quality Improvement, Governance and Engagement Committee membership attendance 2015/16

The Quality Improvement and Governance Committee meeting is quorate if a minimum of four members are present, providing this includes either the Chair or Vice Chair of the Committee and an elected clinical member. The Committee has been quorate at each meeting during 2015/16**.**

Finance and Performance Committee

The Finance and Performance Committee provides a framework which proactively manages the CCG's financial, performance and quality innovation, productivity and prevention (QIPP) agenda.

It comprises the following voting members, or their nominated deputy:

- Chief Finance Officer;
- Chief Operating Officer;
- Clinical Chief Officer (Accountable Officer);
- Elected Governing Body Clinical Lead for contracts, finance and performance;
- Elected Governing Body Clinical Lead;
- CCG Chair; and
- Head of Finance.

The Finance and Performance Committee has operated throughout the reporting year and formed part of the review of Committee effectiveness and efficiency and its result of significant assurance.

The Committee reviews and has oversight of:

- Performance against national and local targets;
- 'In-year' financial position, receiving a detailed report of the financial position and progress towards meeting the targets within the CCG's financial plan and its financial strategy;
- Implementation of QIPP schemes, receiving updates on both the financial and activity performance to inform the achievement of planned schemes;
- Implementation of investments against the plans with business cases for the transformation of services; and
- Outlining financial activity and delivery against key performance indicators across contractual duties.

Membership	May 15	Jun 15	Jul 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
GP elected lead for contracts, finance and performance (Chair) or deputy	✓	✓	✓	✓	✓	✓	✓	✓		✓
Chief Operating Officer or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clinical Chief Officer or deputy	✓		✓		✓		✓	✓	✓	
Chief Finance Officer (Vice Chair) or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
CCG Chair	✓	✓	✓	✓	✓	✓		✓	✓	✓
Head of Finance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GP elected lead	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Table 15: Finance and Performance Committee membership attendance 2015/16

The Committee is quorate if a minimum of four members are present, providing this includes a minimum of two elected Governing Body clinical leads and a minimum of two members of the senior management team. It has been quorate for decision making at each meeting during 2015/16.

During this reporting year, the Committee has taken a strong lead in reviewing the considerable financial issues and challenges that come with being a national New Models of Care Vanguard to ensure that resources are wisely and effectively used to gain the maximum benefits for our patients and public.

The Committee reviews business cases and has standing items on its agenda for this work.

It has received and approved the CCG's Financial Strategy and strategies for Estates and IM&T, ensuring that the interdependent work is considered against the overall CCG aims and objectives.

The Committee remains focused on the CCG's financial performance, and is also sighted on the financial considerations and implications of work taking place across the Fylde Coast and Lancashire.

Primary Care Commissioning Committee

This Committee is the corporate decision making body for the management of the primary care function, under delegated authority from NHS England. The purpose of the Committee is to enable members to make collective decisions on the review, planning and procurement of primary care services in Fylde and Wyre. The functions are undertaken in the context of a desire to promote local CCG involvement in co-commissioning General Practice services to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

The Committee was established in April 2015 and, in April 2016, an internal audit review provided significant assurance that the systems and processes to effectively undertake the delegated commissioning function were operating effectively, albeit to some extent still evolving.

The Committee comprises the following voting members:

- CCG Chair (Chair)
- Lay member (governance) (Vice Chair)
- Lay member (patient and public engagement)
- Chief Nursing Officer
- Chief Operating Officer
- Chief Finance Officer
- Secondary Care Doctor

Membership	May 15	Sept 15	Nov 15	Feb 16	Mar 16
Chair	✓	✓	✓	✓	✓
Lay Member, governance	✓	✓	✓	✓	✓
Lay Member, patient and public engagement	✓	✓	✓	✓	✓
Secondary care doctor	✓	✓	✓	✓	
Chief Finance Officer	✓	✓	✓	✓	✓
Chief Nursing Officer	✓	✓			✓
Chief Operating Officer	✓	✓	✓	✓	✓

Table 16: Primary Care Commissioning Committee membership attendance 2015/16

The Committee is quorate if a minimum of three voting members are present, providing this includes the Lay Chair or Vice Chair and one executive officer. The Committee has been quorate at each meeting during 2015/16.

Clinical Commissioning Committee

The Clinical Commissioning Committee provides assurance to the Governing Body that the CCG is commissioning services in line with the needs of the local population and the strategic objectives of the CCG. It has operated throughout the reporting period.

It formed part of the review of Committee effectiveness and efficiency and its result of significant assurance.

It Committee comprises the following voting Members (or their nominated deputy):

- Clinical Chief Officer;
- Chief Operating Officer;
- Chief Nursing Officer;
- Chief Finance Officer;
- Elected clinical programme leads,
- Secondary care doctor

The Committee is responsible for overseeing the development of the commissioning strategy, ensuring the meaningful involvement of stakeholders and our public in its development. Its main focus over the past year has been the proactive development and implementation of the New Models of Care programme.

The Committee is seen as the final decision making forum prior to any formal discussions and approvals at the Governing Body and it provides assurance that the commissioning and decommissioning of services is evidence-based and meets national and local requirements. Members take a lead role in work taking place across the Fylde Coast and Lancashire, ensuring CCG decisions take into account this wider collaborative and partnership work.

Membership	Apr 15	May 15	Jun 15	Jul 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Clinical Chief Officer (Chair) or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Operating Officer or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Nursing Officer or deputy	✓	✓		✓		✓	✓	✓	✓		✓
Chief Finance Officer or deputy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Secondary Care Doctor or deputy	✓	✓		✓	✓		✓	✓	✓	✓	✓
Elected Clinical Programme Leads	**7**	**7**	**6**	**7**	**4**	**5**	**6**	**5**	**5**	**7**	**7**

Table 17: Clinical Commissioning Committee membership attendance 2015/16

The Committee is quorate if a minimum of four members are present, providing this includes either the Chair or Vice Chair of the Committee and two elected clinical members. The Committee has been quorate at each meeting during 2015/16.

Wider collaborative arrangements

The CCG has enhanced joint working and funding arrangements with Fylde and Wyre Borough Councils and ensures planning for future health services is aligned to approve Local Plans. Our local authority partnership work has included creating a 'Healthcare Hub' at Wyre Civic Centre in Poulton.

Governing Body members work together to understand local communities' needs, agree priorities and encourage joint working to facilitate better joined-up services, with a quality and outcomes based focus.

The CCG has the vice chair role on the Lancashire Health and Wellbeing Board. This provides a forum for key leaders from the health and care system to work together to improve the health and wellbeing of local people and reduce health inequalities through the Health and Wellbeing Strategy and the Better Care Fund.

Locally, the Fylde and Wyre Health and Wellbeing Partnership (HWP) leads on the strategic co-ordination of health and wellbeing priorities and commissioning across local authority, the NHS, social care, the housing sector and public health to secure better outcomes for the population of Fylde and Wyre, better quality of care for patients and care users and better value for the taxpayer.

Lancashire Health and Wellbeing Board has given Fylde and Wyre HWP delegated responsibility to oversee the development and delivery of the Lancashire Better Care Fund plan.

The CCG also plays an active role in 'Healthier Lancashire' work to integrate, redesign and improve services across the county. Our strengthened operational Scheme of Delegation supports efficient and effective decision making at this level whilst maintaining the appropriate levels of control and reporting. This also supports governance and reporting arrangements for the development of New Models of Care across our CCG area and the Fylde Coast.

Other service provisions

NHS Midlands and Lancashire Commissioning Support Unit (CSU) provides a range of support services to allow the CCG to operate and perform its functions in the most cost effective way. Performance and quality of services are monitored through regular liaison and meetings directly with the CSU and also through the Service Audit Reports which are considered by the CCG's Audit Committee. All appropriate reports from our support services are to be received and considered as part of finalising the annual accounts and governance requirements for 2015/16.

The CCG risk management framework

The CCG's Integrated Risk Management Framework has been agreed by the Governing Body and is embedded within the CCG through:

- Compliance with legislative and regulatory requirements;
- Prime financial policies;
- Committees of the Governing Body;
- The Governing Body assurance framework;
- The corporate risk register;
- Internal performance management processes; and
- Policies and procedures.

The policies and procedures in place in the CCG plus internal performance management and monitoring processes are designed to prevent and deter risks arising. The risk registers and the assurance framework provide the mechanisms for documentation, evaluation and reporting of risk and associated mitigating actions. The committee system in place within the CCG (including Executive Management Team, Heads of Service meetings, Audit Committee and Quality Committee) is designed to ensure that the CCG, its members and committees are fully sighted on risks and the

potential consequence of those risks, including the impact on the organisation. These mechanisms also enable mitigating actions to be identified, implemented and monitored.

The Clinical Chief Officer remains accountable, but delegates responsibility to executive officers to deliver organisational objectives while ensuring that there is a high standard of public accountability, probity and performance management. The corporate risk register and Governing Body assurance framework set out identified risks, risk owners and how risks will be managed. These documents were reviewed by the Quality Improvement, Governance and Engagement Committee before going to Governing Body three times in 2015/16. The Audit Committee reviews the corporate risk register three times a year at its meetings and assesses the suitability and adequacy of the assurance framework.

The Governing Body sets the levels of risk tolerance and risk appetite annually using the Good Governance Institute's 'Risk Appetite for NHS Organisations' matrix; the CCG's control of its principal risks are recorded in the Governing Body assurance framework.

The overall approach and culture within the CCG is that of support and continuous organisational understanding and learning; however, staff are held accountable if codes of practice, policies and procedures or safe systems of working have not been followed. We carry out equality impact assessments as part of our core business, continually review our approach to risk management and provide regular training and information.

The Local Anti-fraud Specialist reports its work to each Audit Committee meeting and carries out staff briefing sessions and communication pieces to maintain the CCG's drive in this regard.

Incident reporting is widely encouraged in the CCG and our Constitution reflects the protection of our embedded whistleblowing policies and procedures. The CCG has linked policies for bribery and corruption, which are aligned to safeguarding policies and reflect the latest best practice and issued guidance.

Patient and public engagement is strongly encouraged and sought to provide informed views on our services and seek areas for improvement. There continues to be wide public and stakeholder engagement to inform our vision for health and care, including the development of the New Models of Care across the Fylde Coast.

This also helps us to evaluate and manage service risks, which are more likely during this period of transformational change.

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

An understanding of and adherence to risk management arrangements is the responsibility of everyone within the CCG and every individual staff member has the right to identify any potential or actual risk for service users, staff and the organisation.

The CCG and CSU provide dedicated resources, to ensure compliance with the organisation's risk management responsibilities and requirements.

Risks are assessed in accordance with the organisational Integrated Risk Management Framework and policies and they are routinely reported to the Audit Committee and discussed with Mersey Internal Audit Agency.

Once an appropriate risk has been identified, a risk assessment form is completed and a risk rating is assigned according to the severity and likelihood of that risk (using a 5x5 risk assessment matrix for the level of severity and likelihood) and recognising any existing controls in place which may mitigate that risk. The risk owner decides how it should be managed and mitigated and it is entered in the corporate risk register. Risks which impact upon corporate objectives and are of a significant level are reported within the Governing Body assurance framework.

During the reporting period risks were identified from a variety of sources including:

- Overall commissioning activity;
- Service complaints;
- incidents and service quality;
- Internal/external audit reports;
- Team meetings; and
- Stakeholder meetings.

At March 2016, the top 3 risks identified on the Governing Bodies Corporate Risk Register and Assurance Framework were:

- Higher than expected mortality rates at the main acute provider (risk score 20),
- Risk of Insufficient / Inadequate Care Home (nursing & residential) places for Fylde &Wyre CCG Residents (risk score 16) and,
- High Demand for CAMHs Tier 4 Services resulting in delay accessing beds (risk score 16).

New risks identified in 15/16 have included:

- the CCG having no overall Estates Strategy to underpin the 20/30 vision, which has now been addressed;
- Failure to maintain the impact on the improvements to healthcare through New Models Of Care which is being continually mitigated through significant commissioning activity as a Vanguard organisation;
- Risk to destabilisation of Care Home Sector if there is a closure of 28 nursing home beds due to sub-optimal and or unsafe care - a risk which was managed through a piece of multi-agency work.

During 2015/16 the Audit Committee and the Governing Body of the CCG identified some areas for improvement in relation to risk identification and recording on the risk register. Consequently, the CCG has engaged the support of the CSU Corporate Governance & Risk Manager to implement these improvements. This was underpinned by a development session for risk owners and Governing Body members, to ensure there is collective understanding about the risks described on the register and assurance that the identified controls are effective and meaningful. This development session was delivered by the CCG's Internal Auditor. Improvements include recording the movement of risks, following each bi-monthly review and recording the target residual risk score for each risk. The Internal Auditor reviewed the CCG Assurance Framework in 2015/16 and recommended that the organisation's Assurance Framework could be more visibly used by the Governing Body. To address this, the workshop will be carried out each year and the Head of Quality will meet with the Governing Body Chair, to ensure there is alignment between the risks featuring on the register and the subjects brought to the Governing Body meetings via formal papers and briefings.

The Quality Improvement, Governance and Engagement Committee effectiveness was reviewed in 2015/16. This concluded that the Quality, Improvement, Governance and Engagement Committee is delivering most of its core duties effectively and has begun to develop and embed the actions associated with its wider remit. A small number of recommendations arising from this audit have been fully implemented.

Executive leads review the risks quarterly before the corporate risk register is presented to the Quality Improvement Governance and Engagement Committee. There is an opportunity to discuss any risk changes, or new potential implications, identified at the weekly Executive Management Team meetings.

Where a risk is not tolerable at the current level identified, an action plan is drawn up to set out the steps to be taken to manage and to mitigate that risk, with a nominated responsible and accountable lead officer and with a deadline for completion of each action. Appropriate oversight and scrutiny on all such risks is also maintained by the CCG's Internal Auditors throughout the year and they can report any concerns and issues at Audit Committee meetings.

The effectiveness of these overall procedures and governance structures continue to be tested by the CCG via review, assessment and appraisal to ensure we comply with authorisation requirements. Governing Body members ensure that these issues remain firmly on their agenda and are given priority. The CCG also proactively works with its partners within the wider economy of the Fylde Coast and Lancashire to ensure that degree of risk assessment, scrutiny, challenge and assurance is maintained from the wider collaborative service perspective too.

To support this, we are:

- Revising Committee Terms of Reference, including the responsibilities and delegated powers of Directors and Committees; and

- Clarifying reporting lines, accountabilities and operational effectiveness between the Governing Body, its Committees and the Executive Team.

The CCG 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.

A robust system of internal control has been in place in the CCG for the year ending 31 March 2016 and up to the date of approval of the Annual Report and Accounts. Internal control systems stem from the CCG's Constitution and the procedures, policies and practices that are in place across the organisation. There are specific divisions of duties across roles within the organisation and corresponding controls which are embedded through training, experience and peer review. I believe that the good practices that the CCG strives to operate, lead to the sound internal control arrangements that the CCG has in place and has had assured through Internal Audit.

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 assurance to the CCG other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We have robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are continuing to develop information governance processes and procedures in line with the information governance toolkit. All staff undertake annual information governance training and we have introduced a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

The CCG recognises that the information it holds is one of its key assets and has managed risks to data security in line with the toolkit requirements. The Senior Information Risk Owner (SIRO) – a role

that is undertaken by the Chief Finance Officer - has overseen the management of data security protection through specialist support from the CSU and internally through the appointment of information asset owners. The CCG has reviewed and completed information security risk assessments to ensure ongoing proactive risk management and data security protection.

The CCG has been provided with 'significant assurance' in respect of an internal audit review of the information governance toolkit, conducted during January/February 2016 and our own self-assessment has indicated a level two, or above on all standards.

Control measures continue to be in place to ensure risks to data security are managed and controlled. The CCG has an information risk management process in place led by the SIRO. Information asset owners and administrators are identified to cover the CCG's main systems and records stores, along with information held at a team level. All CCG laptops and USB sticks are encrypted and iPads have password protection.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation against identified risks.

The CCG has reviewed its Information Governance policies this year. Information Governance is routinely discussed and reported through the CCG's Finance and Performance Committee**.**

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

We are focused on maintaining a robust and effective financial control environment, ensuring strong underpinning financial management, and delivering the sustainable financial resources, QIPP plans and the redirection of funds to achieve our strategic and operational plans. Financial pressures, allocation levels and the challenges of our transformational agenda inevitably enhance and heighten our financial risks. The CCG has an approved Financial Strategy (this has been reassessed in 2015/16) and the organisation has clear oversight on the issues and strong and prompt management of any financial risks. This approach has again ensured that the CCG has met all of its financial requirements again in 2015/16. It is critical that the CCG maintains this financial sustainability going forward to deliver its vision for improved health services.

Monthly reports on the financial position and the inherent risks go to the Finance and Performance Committee and are referenced to the Audit Committee and discussed at Governing Body. Any remedial action or recommended approaches to addressing any resulting issues and risks are promptly identified. A key part of the CCG financial reporting and business intelligence, and its Financial Strategy in 2015/16 and into future years, will surround the CCG's transformational agenda and the delivery of New Models of Care

We have continued to prioritise services according to the financial resources available. Plans are clearly defined and approved with rigorous oversight and scrutiny, a programme management approach is adopted to monitoring, reporting and implementation with clear and defined responsibility and accountability for the plan's delivery.

Where priorities are determined and approved on a collaborative, partnership or economy wide basis, full recognition of those requirements is reflected within the CCG's plans and resource utilisation. This also includes any responsibilities the CCG holds for any appropriate delegated or hosted services. The CCG's operational Scheme of Delegation has been strengthened in this reporting year to reflect internal changes to its governance and the delegation implications, the specific delegated powers assigned to the CCG for Primary Care Commissioning responsibilities and for that wider working and collaborative approach. This refresh to the Scheme of Delegation has supported the need for improved and informed decisions to be made more promptly, by the appropriate person, or committee, or the officers representing the CCG in those wider forums but does not override the

requirements for approvals and robust control to be exercised through the CCG's Governing Body. This approach is viewed as a means of ensuring strong control is maintained, but being pragmatic in allowing service decisions to be taken efficiently and effectively.

Mersey Internal Audit Agency, via its reports to the Audit Committee and liaison with External Audit, is also a key assurance partner to confirm that value for money is being achieved by the CCG. The CCG has again met its duties in this regard for 2015/16**.**

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

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

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, the executive managers, the clinical leads and the dedicated resources assigned to the governance and control arrangements within CCG who have responsibility for developing and maintaining the internal control framework. I have also drawn upon performance information and business intelligence and reports and comments from our external auditors and NHS England. I am satisfied that the governance structures across the CCG have been effective over this reporting period.

The respective responsibility and delegated powers of Directors and Committees is clear and the processes and procedures have been reviewed for their efficiency and effectiveness, together with Internal Audit assurance this year. The CCG has individual and collective review and assessment arrangements to ensure high quality performance. Information is submitted in a clear, accurate and timely manner that identifies risk which is in line with the CCG's duties, responsibilities, and its expectations. I am satisfied with the degree of challenge, rigour and oversight that the Governing Body and committees provide.

Our Governing Body assurance framework provides me with evidence that the effectiveness of controls that manage risks to the Clinical Commissioning Group achieving its principal objectives have been reviewed. This has continued to be updated to reflect the strategic and operational objectives of the CCG and, together with the corporate risk register, is considered routinely by the CCG's Quality Improvement, Governance and Engagement Committee and the Audit Committee. The risk profile of the CCG largely reflects a conservative approach to risk taken over the course of the year to ensure service effectiveness, stability, quality and patient safety are paramount. This includes continually striving to drive improvements in mortality rates, ambulance targets and reducing the risk of serious infections such as MRSA and *C.Difficile* for example.

Despite there being no high level risks that have led to serious consequences and formal reporting in this last year, the CCG, as with many other NHS organisations, continues to carry, address and mitigate very significant challenges with their inherent high level potential risks. Some of the highest risks carried by the CCG remain around the achievement of service quality and the delivery of specific service performance targets by its providers, as well as the significant financial pressures and regulatory challenges they currently face. Where there is poor performance, we have put systems and processes in place to understand why and what is being done to address it.

The monitoring, assessment, reporting and challenge to address and mitigate such issues falls across all the governance structures in the CCG, namely through;

- The specific responsibilities of directors, committees and the Executive Management Team;
- The clear reporting lines between the Council of Members, the Governing Body and its committees;
- The assurance processes undertaken with Internal Audit and NHS England;
- Public and patient engagement; and
- Performance appraisal across the CCG at an individual, group and organisational level.

The audit review undertaken for this financial year, and provided as part of the Director of Internal Audit Opinion (Head of Internal Audit Opinion), gave 'Significant Assurance' and concluded that key controls have been adequately designed and have been operating effectively to deliver the key objectives of the system, function, or process. The overall objective of the risk management element of the review is to ensure that arrangements for capturing risks, and maintaining and updating risk registers is robust and has provided a clear audit trail. This review also assessed whether the CCG has a clearly defined and documented strategy in place for managing risks, defined Governing Body level responsibility and committee structure that supports the risk management accountability arrangements within the organisation. Additionally, evidence that risk management is embedded throughout the organisation has been sought, including the provision of training for staff and members at all levels.

The CCG's risk register and assurance framework continues to be actively monitored and updated in line with the integrated risk management framework supporting the CCG's systems of internal control.

Capacity to handle risk

We provide strong leadership in supporting and facilitating risk management understanding, awareness, assessment and reporting and it is embedded into our strategic planning and prioritisation process. The CCG provides training to support the Governing Body and its committee members to develop their own risk awareness and tolerance of risk and ensure best practice.

All staff members are required to complete annual training to ensure they have the capabilities and knowledge of basic risk management principles, including fraud, and can foresee potential immediate and future risks. Information is also shared through regular staff communication meetings as well as guidance and support from a dedicated risk manager within the CCG. Mersey Internal Audit Agency worked in partnership with the CCG in delivering appropriate training and development sessions.

Internal audit and internal control

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

Director of Internal Audit opinion (Head of Internal Audit opinion)

The Director of Internal Audit has issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control, concluding that:

"Significant Assurance can be given that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design or inconsistent application of controls put the achievement of a particular objective at risk."

The CCG has implemented robust procedures for its key financial systems, which have been reviewed as appropriate in line with the annual audit plan and reported to the Audit Committee. Recommendations made by internal audit have been implemented to address the weaknesses identified and progress is reported to the Audit Committee.

During the year there have been no Limited Assurance opinions provided for the organisation:

The CCG assures itself on the validity of the Annual Governance Statement information triangulating information including:

- Internal Audit report findings;
- Engagement with Internal Audit in the production of the Statement; and
- Consultation with Members of the organisation's Audit Committee (including External Audit and Lay Members) on the accuracy of the contents of the Statement.

Pensions assurance

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

UK Modern Slavery Act

The Modern Slavery Act 2015 requires all NHS bodies with a turnover in excess of £36M to disclose the steps they have taken to ensure that slavery and human trafficking do not exist in their business or their supply chains. This is an area of low risk for the CCG as the organisation largely commissions services using standard framework contracts and has monitoring systems in place to reduce or negate this activity.

Data quality

The CCG provides quality business intelligence and information to the Council of Members, the Governing Body and its committees to support and facilitate prompt and informed decision making.

Best practice in quality of services and the assurances sought continues to be promoted by the CCG, and is sought in the support arrangements and the information and intelligence it receives from the CSU through a clear internal chain of responsibility and a route for challenge.

We widely apply important basic assurance techniques like internal peer review, use of audit and the extensive use of internal guidance. The CCG relies on the assurances provided through Service Audit Reports for the CSU service provision, which have been provided for 2015/16 and reported through the CCG's Audit Committee.

Business Critical Models

The CCG's Executive Management Team (EMT) is sighted on the CSU service provision and all other business critical models. This is managed through attendance at joint meetings with providers and EMT discussions. The CSU Head of Transformation and Service Redesign also attends the CCG weekly EMT meetings in order to ensure there is on-going review and refreshment of provision.

Business critical models are expected to reflect national requirements and guidelines and are subject to regular external review, the outputs of which are reported to the CCG through Service Auditor reports. The Service Auditor Reports are scrutinised by the CCG's Audit Committee.

Any risks identified regarding business critical models will be included as appropriate on the CCG's risk register and therefore will follow the CCG's risk management process. Any recommended actions will be reported to the CCG's Governing Body.

Within the CCG Business Critical Models, information may be identified that has to form part of the CCG's Information Asset Register, with a suitably qualified Information Asset Owner. That has to be publicly available; subject to data confidentiality issues should they apply.

Data security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

As a result of high profile data breaches nationally and the CCG's commitment to embed the information governance agenda across the CCG, staff awareness of the importance of reporting all information security incidents and near misses has been raised. This is reflected in the number of relatively minor (levels 0-1) internal incidents reported in the data shown below.

Following the issue of national criteria in 2008, the CCG has to categorise all incidents involving personal confidential data. These are considered serious untoward incidents when involving data loss or confidentiality breaches. Table 19 provides definitions of the classification of incident severity the CCG must apply, zero being the lowest and five the highest.

Organisations registered with the HSCIC's IG Toolkit are required to report incidents that are categorised at Level 2 or above via the IG Incident Reporting Tool on the IG Toolkit. Incidents, where appropriate, may be escalated to organisations such as Department of Health and the Information Commissioner's Office. The HSCIC will publish all incidents reported and categorised at Level 2 or above on a quarterly basis via the IG Toolkit.

0	1	2	3	4	5
No significant reflection on any individual or body. Media interest very unlikely.	Damage to an individual's reputation. Possible media interest, e.g. celebrity involved.	Damage to a team's reputation. Some local media interest that may not go public.	Damage to a service's reputation. Low key local media coverage.	Damage to an organisation's reputation. Local media coverage.	Damage to NHS reputation. National media coverage.
Minor breach of confidentiality. Only a single individual affected.	Potentially serious breach. Less than five people affected or risk assessed as low, e.g. files were encrypted.	Serious potential breach and risk assessed high, e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality, e.g. up to 100 people affected.	Serious breach with either particular sensitivity, e.g. sexual health details or up to 1,000 people affected.	Serious breach with potential for ID theft or over 1,000 people affected.

Table 19: Definitions of the classification of incident severity

All NHS organisations are required to summarise all such incidents classified as 0-1 in their annual report and individually detail incidents classified 2-5. The latter classification of incident must also be reported to NHS England and the Office of the Information Commissioner.

During the period 1 April 2015 to 31 March 2016 there was a total of one incident categorised 0-1 (low level), see table 20 for details. No incidents were reported within the CCG that would be categorised in the higher severity levels (2-5). All incidents have been investigated and policies and procedures revised in light of findings.

Summary of serious untoward incidents involving person identifiable data classified 0-1; 01 April 2015 – 31 March 2016		
Category	**Nature of incident**	**Number**
i	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises.	0
ii	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises.	0
iii	Insecure disposal of inadequately protected electronic equipment, devices or paper document.	0
iv	Unauthorised disclosure.	1
v	Other.	0

Table 20: Summary of serious untoward incidents involving person identifiable data

Discharge of statutory functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with the involvement of external legal experts, to ensure we comply with legislation. That legal advice also informed the matters reserved for the Council of Members (the 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 regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Conclusion

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways outlined above. The DoIA has also provided '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.

My review concludes that NHS Fylde and Wyre Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Dr Tony Naughton
Clinical Chief Officer
24 May 2016

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS FYLDE AND WYRE CCG

We have audited the financial statements of NHS Fylde and Wyre CCG for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. 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 Fylde and Wyre 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 set out on page 14, 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 Fylde and Wyre CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Timothy Cutler for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
One St Peter's Square
Manchester
M2 3AE

26 May 2016

Financial Statement and Notes

Data entered below will be used throughout the workbook:

Entity name:	NHS Fylde and Wyre Clinical Commissioning Group
This year	2015-16
This year ended	31-March-2016
This year commencing:	01-April-2015

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

Please review and adjust to local reporting requirements

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The Primary Statements:

Notes to the Accounts

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	1,935	1,920
Operating Expenses	5	232,609	203,226
Other operating revenue	2	(333)	(1,071)
Net operating expenditure before interest		**234,211**	**204,075**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,587	1,630
Operating Expenses	5	1,658	2,101
Other operating revenue	2	(8)	(112)
Net administration costs before interest		**3,237**	**3,619**
Programme Income and Expenditure			
Employee benefits	4.1.1	348	290
Operating Expenses	5	230,951	201,125
Other operating revenue	2	(325)	(959)
Net programme expenditure before interest		**230,974**	**200,456**
Total comprehensive net expenditure for the year		**234,211**	**204,075**

The notes on pages 5 to 28 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Current assets:			
Trade and other receivables	17	992	507
Cash and cash equivalents	20	13	2
Total current assets		**1,005**	509
Total assets		**1,005**	509
Current liabilities			
Trade and other payables	23	(11,846)	(10,293)
Total current liabilities		**(11,846)**	(10,293)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,841)**	(9,784)
Assets less Liabilities		**(10,841)**	(9,784)
Financed by Taxpayers' Equity			
General fund		(10,841)	(9,784)
Total taxpayers' equity:		**(10,841)**	(9,784)

The notes on pages 5 to 28 form part of this statement

The financial statements on pages 1 to 28 were approved by the Governing Body on 24 May 2016 and signed on its behalf by:

Clinical Chief Officer (Accountable Officer)

Name: Dr Tony Naughton

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

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2015-16		
Balance at 1 April 2015	(9,784)	**(9,784)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16		
Net operating expenditure for the financial year	(234,211)	(234,211)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(234,211)**	**(234,211)**
Net funding	233,154	233,154
Balance at 31 March 2016	**(10,841)**	**(10,841)**

	General fund £000	Total reserves £000
Changes in taxpayers' equity for 2014-15		
Balance at 1 April 2014	**(7,071)**	**(7,071)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15		
Net operating costs for the financial year	(204,075)	(204,075)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(204,075)**	**(204,075)**
Net funding	201,362	201,362
Balance at 31 March 2015	**(9,784)**	**(9,784)**

The notes on pages 5 to 28 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		(234,211)	(204,075)
(Increase)/decrease in trade & other receivables	17	(485)	770
Increase/(decrease) in trade & other payables	23	1,553	1,900
Net Cash Inflow (Outflow) from Operating Activities		**(233,143)**	(201,405)
Cash Flows from Financing Activities			
Net Funding Received		233,154	201,362
Net Cash Inflow (Outflow) from Financing Activities		**233,154**	201,362
Net Increase (Decrease) in Cash & Cash Equivalents	20	**11**	(43)
Cash & Cash Equivalents at the Beginning of the Financial Year		**2**	45
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**13**	2

The notes on pages 5 to 28 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *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 clinical commissioning groups, 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 clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

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

1.5 Charitable Funds

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.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.
If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

- The assets the clinical commissioning group controls;
- The liabilities the clinical commissioning group incurs;
- The expenses the clinical commissioning group incurs; and,
- The clinical commissioning group's share of the income from the pooled budget activities.

If the clinical commissioning group is involved in a "jointly controlled assets" arrangement, in addition to the above, the clinical commissioning group recognises:

- The clinical commissioning group's share of the jointly controlled assets (classified according to the nature of the assets);
- The clinical commissioning group's share of any liabilities incurred jointly; and,
- The clinical commissioning group's share of the expenses jointly incurred.

From 1st April 2015 the CCG has entered into pooled budget arrangements hosted by Lancashire County Council in respect of the Better Care Fund (BCF) Initiative. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.
The BCF section 75 agreement in Lancashire is considered to fall under the provisions of a 'joint operation' due to the following factors:
- Relevant decisions must be unanimous
- All members hold providers to account for delivery
- Risks are borne equally.

All partners account for their own share of the pool's income, expenditure, assets and liabilities in line with the agreement.

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:
The clinical commissioning group's management has reviewed the organisation's portfolio of leases and judged that all leases should be classified as operating leases.

Notes to the financial statements

1.7.2 **Key Sources of Estimation Uncertainty**

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

There are a number of accruals within the Statement of Financial Position where estimation techniques are applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimates are prescribing costs, and expenditure relating to secondary, tertiary and independent sector hospital activity information.

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

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

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

1.11.2 **Valuation**

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

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

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

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

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

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

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

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

1.11.3 **Subsequent Expenditure**

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

Notes to the financial statements

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

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

1.13 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.14 **Donated Assets**

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

1.15 **Government Grants**

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

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

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

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

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

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

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

Notes to the financial statements

1.17.2 **The Clinical Commissioning Group as Lessor**

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.
The clinical commissioning group was party to no leases during 2015/16 as lessor (nil in 2014/15).

1.18 **Private Finance Initiative Transactions**

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

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

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were either included or excluded from the Statement of Financial Position as at 31 March 2016 (nil at 31 March 2015).

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.

1.20 **Cash & Cash Equivalents**

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

1.21 **Provisions**

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

- Timing of cash flows (0 to 5 years inclusive): Minus 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%)
- All employee early departures: Plus 1.37% (2014-15: plus 1.30%)

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

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

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

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

1.26 **Contingencies**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

Notes to the financial statements

1.27 **Financial Assets**

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

Financial assets are classified into the following categories:

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

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

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

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

1.27.2 **Held to Maturity Assets**

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

1.27.3 **Available For Sale Financial Assets**

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

1.27.4 **Loans & Receivables**

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

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

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

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

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

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

1.28 **Financial Liabilities**

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

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

1.28.1 **Financial Guarantee Contract Liabilities**

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

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

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

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

1.28.3 **Other Financial Liabilities**

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

1.29 **Value Added Tax**

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

1.3 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

Notes to the financial statements

1.32 **Losses & Special Payments**

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

1.33 **Subsidiaries**

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

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

1.34 **Associates**

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

1.35 **Joint Ventures**

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

1.36 **Joint Operations**

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

1.37 **Research & Development**

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 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.

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Education, training and research	0	0	0	124
Non-patient care services to other bodies	209	7	202	165
Other revenue	124	1	123	782
Total other operating revenue	**333**	**8**	**325**	**1,071**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services. Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the clinical commissioning group and credited to the General Fund.

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	333	8	325	1,071
Total	**333**	**8**	**325**	**1,071**

4. Employee benefits and staff numbers

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	1,531	1,336	195	1,238	1,043	195	293	293	0
Social security costs	161	161	0	139	139	0	22	22	0
Employer Contributions to NHS Pension scheme	243	243	0	210	210	0	33	33	0
Gross employee benefits expenditure	**1,935**	**1,740**	**195**	**1,587**	**1,392**	**195**	**348**	**348**	**0**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**1,935**	**1,740**	**195**	**1,587**	**1,392**	**195**	**348**	**348**	**0**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**1,935**	**1,740**	**195**	**1,587**	**1,392**	**195**	**348**	**348**	**0**

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	1,560	1,366	194	1,292	1,179	113	268	187	81
Social security costs	145	145	0	136	136	0	9	9	0
Employer Contributions to NHS Pension scheme	215	215	0	202	202	0	13	13	0
Gross employee benefits expenditure	**1,920**	**1,726**	**194**	**1,630**	**1,517**	**113**	**290**	**209**	**81**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**1,920**	**1,726**	**194**	**1,630**	**1,517**	**113**	**290**	**209**	**81**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**1,920**	**1,726**	**194**	**1,630**	**1,517**	**113**	**290**	**209**	**81**

4.2 Average number of people employed

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**44**	**41**	**3**	37

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Full Time Equivalent Days Lost to Sickness	220	158
Annual Average Number of Full Time Equivalents Employed	42	32
Average working Days Lost	**5.24**	**4.94**

The clinical commissioning group did not have any persons retired early on ill health grounds (nil in 2014/15).
There were no additional Pensions liaibilities accrued in the year (nil in 2014/15).

4.4 Exit packages agreed in the financial year

The clinical commissioning group has not agreed any exit packages in 2015/16 (nil in 2014/15).

The clinical commissioning group's Annual Report contains further disclosures about staff pay within the Remuneration and Staff report (see page 19 of the Annual Report), including salary and pension entitlements of Senior Managers, staff composition and off-payroll engagements.

4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

4.5.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £243,184 were payable to the NHS Pensions Scheme (2014-15: £215,620) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay (2014-15: 14%). 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.

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	1,473	1,125	348	1,445
Executive governing body members	462	462	0	475
Total gross employee benefits	**1,935**	**1,587**	**348**	**1,920**
Other costs				
Services from other CCGs and NHS England	3,016	1,127	1,889	2,847
Services from foundation trusts	133,600	0	133,600	130,570
Services from other NHS trusts	8,098	50	8,048	7,088
Services from other NHS bodies	16	5	11	5
Purchase of healthcare from non-NHS bodies	31,538	0	31,538	27,871
Chair and Non Executive Members	212	212	0	249
Supplies and services – clinical	0	0	0	17
Supplies and services – general	22	10	12	20
Consultancy services	0	0	0	58
Establishment	199	168	31	481
Transport	0	0	0	1
Premises	722	12	710	1,034
Audit fees	54	54	0	69
Other non statutory audit expenditure				
· Other services	0	0	0	1
Prescribing costs	30,347	0	30,347	28,874
GPMS/APMS and PCTMS	22,917	0	22,917	3,195
Other professional fees excl. audit	5	5	0	25
Grants to other public bodies	814	0	814	341
Research and development (excluding staff costs)	0	0	0	158
Education and training	15	15	0	30
CHC Risk Pool contributions	1,034	0	1,034	292
Total other costs	**232,609**	**1,658**	**230,951**	**203,226**
Total operating expenses	**234,544**	**3,245**	**231,299**	**205,146**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Fylde and Wyre CCG has been approved under delegated commissioning arrangements which means that the CCG have assumed full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2015. This increase in expenditure can be seen within the GPMS/APMS and PCTMS line.

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	7,306	44,286	6,995	30,205
Total Non-NHS Trade Invoices paid within target	7,231	43,858	6,948	30,164
Percentage of Non-NHS Trade invoices paid within target	**98.97%**	**99.03%**	**99.33%**	**99.86%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,011	146,769	2,018	144,150
Total NHS Trade Invoices Paid within target	2,002	146,746	2,007	144,125
Percentage of NHS Trade Invoices paid within target	**99.55%**	**99.98%**	**99.45%**	**99.98%**

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

The clinical commissioning group has not made any interest payments in respect of overdue invoices (nil in 2014/15).

7 Income Generation Activities

The clinical commissioning group does not undertake any income generation activities (nil in 2014/15).

8. Investment revenue

The clinical commissioning group had no investment revenue in the financial year (nil in 2014/15).

9. Other gains and losses

The clinical commissioning group had no other gains or losses in the financial year (nil in 2014/15).

10. Finance costs

The clinical commissioning group incurred no finance costs in the financial year (nil in 2014/15).

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

The clinical commissioning group has not received any gain or incurred any loss relating to the transfer of services or functions in 2015/16 by absorption accounting.

12. Operating Leases

12.1 As lessee

12.1.1 Payments recognised as an Expense

	2015-16			2014-15		
	Buildings £000	**Other £000**	**Total £000**	**Buildings £000**	**Other £000**	**Total £000**
Payments recognised as an expense						
Minimum lease payments	709	4	**713**	799	4	**803**
Total	**709**	**4**	**713**	**799**	**4**	**803**

Whilst our arrangements with Community Health Partnership's Limited and NHS Property Services Limited fall within the definition of operating leases, rental charge for future years has not yet been agreed . Consequently this note does not include future minimum lease

12.1.2 Future minimum lease payments

	2015-16			2014-15		
	Buildings £000	**Other £000**	**Total £000**	**Buildings £000**	**Other £000**	**Total £000**
Payable:						
No later than one year	0	4	**4**	0	4	**4**
Between one and five years	0	4	**4**	0	4	**4**
After five years	0	4	**4**	0	4	**4**
Total	**0**	**12**	**12**	**0**	**12**	**12**

13 Property, plant and equipment

The clinical commissioning group held no property, plant or equipment assets as at 31 March 2016 (nil at 31 March 2015).

13.1 Additions to assets under construction
The clinical commissioning group made no additions to Assets Under Construction in 2015/16 (nil in 2014/15).

13.2 Donated assets
The clinical commissioning group held no Donated Assets during 2015/16 (nil in 2014/15).

13.3 Government granted assets
The clinical commissioning group held no Government Granted Assets during 2015/16 (nil in 2014/15).

13.4 Property revaluation
The clinical commissioning group held no Property during 2015/16 (nil in 2014/15).

13.5 Compensation from third parties
The clinical commissioning group received no compensation from third parties for assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure during 2015/16 (nil in 2014/15).

13.6 Write downs to recoverable amount
No assets were written down to recoverable amounts and there were no reversals of previous write-downs during 2015/16 (nil in 2014/15).

13.7 Temporarily idle assets
The clinical commissioning group had no temporarily idle assets as at 31 March 2016 (nil at 31 March 2015).

13.8 Cost or valuation of fully depreciated assets
The clinical commissioning group had no fully depreciated assets still in use as at 31 March 2016 (nil at 31 March 2015).

13.9 Economic lives
No assets are held by the clinical commissioning group.

14 Intangible non-current assets

14.1 Donated assets
The clinical commissioning group held no Donated Intangible Assets during 2015/16 (nil in 2014/15).

14.2 Government granted assets
The clinical commissioning group held no Government Granted Intangible Assets during 2015/16 (nil in 2014/15).

14.3 Revaluation
The clinical commissioning group revalued no intangible assets during 2015/16 (nil in 2014/15).

14.4 Compensation from third parties
The clinical commissioning group received no compensation from third parties for intangible assets impaired, lost or given up, that is included in the Statement of Comprehensive Net Expenditure during 2015/16 (nil in 2014/15).

14.5 Write downs to recoverable amount
No intangible assets were written down to recoverable amounts and there were no reversals of previous write-downs during 2015/16 (nil in 2014/15).

14.6 Non-capitalised assets
During 2015/16 no significant intangible assets were controlled by the clinical commissioning group but not recognised as assets because they didn't meet the recognition criteria of IAS 38 (nil in 2014/15).

14.7 Temporarily idle assets
The clinical commissioning group had no temporarily idle assets as at 31 March 2016 (nil at 31 March 2015).

14.8 Cost or valuation of fully amortised assets
The clinical commissioning group had no fully depreciated assets still in use as at 31 March 2016 (nil at 31 March 2015).

14.9 Economic lives
The clinical commissioning group held no intangible non-current assets during 2015/16 (nil in 2014/15).

15 Investment property

The clinical commissioning group held no investment property as at 31 March 2016 (nil at 31 March 2015).

16 Inventories

The clinical commissioning group held no inventories as at 31 March 2016 (nil at 31 March 2015).

17 Trade and other receivables	**Current 2015-16 £000**	Current 2014-15 £000
NHS receivables: Revenue	438	43
NHS accrued income	60	0
Non-NHS receivables: Revenue	298	0
Non-NHS prepayments	89	340
Non-NHS accrued income	0	93
VAT	41	31
Other receivables	66	0
Total Trade & other receivables	**992**	**507**
Total current and non current	**992**	**507**

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

17.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	12	0
By three to six months	3	0
By more than six months	55	0
Total	**70**	**0**

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2016 (nil at 31 March 2015).

17.2 Provision for impairment of receivables

The clinical commissioning group did not hold a provision for the impairment of receivables at 31 March 2016 (nil at 31 March 2015).

The clinical commissioning group's aged debt report is reviewed in order to determine the recovery status of the debtor balances. Each item is considered on a case by case basis. No debtor balances were written off in 2015/16 (nil at 31 March 2015).

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2016 (nil at 31 March 2015).

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2016 (nil at 31 March 2015).

20 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	2	45
Net change in year	11	(43)
Balance at 31-March-2016	**13**	**2**
Made up of:		
Cash with the Government Banking Service	13	2

21 Non-current assets held for sale

The clinical commissioning group held no non-current assets held for sale as at 31 March 2016 (nil at 31 March 2015).

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments in 2015/16 (nil in 2014/15).

23 Trade and other payables	**Current 2015-16 £000**	Current 2014-15 £000
NHS payables: revenue	1,930	709
NHS accruals	581	493
Non-NHS payables: revenue	2,124	1,833
Non-NHS accruals	6,881	6,604
Social security costs	25	21
Tax	31	26
Other payables	274	607
Total Trade & Other Payables	**11,846**	**10,293**
Total current and non-current	**11,846**	**10,293**

Other payables include £40K outstanding pension contributions at 31 March 2016 (£34K at 31 March 2015).

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2016 (nil at 31 March 2015).

25 Other liabilities

The clinical commissioning group had no other liabilities as at 31 March 2016 (nil at 31 March 2015).

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2016 (nil at 31 March 2015).

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were either included or excluded from the Statement of Financial Position as at 31 March 2016 (nil at 31 March 2015).

28 Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2016 (nil at 31 March 2015).

29 Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 31 March 2016 (nil at 31 March 2015).

30 Provisions

The clinical commissioning group had no provisions as at 31 March 2016.
Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2016 is £2.68M (31 March 2015 £2.74M).

31 Contingencies

The clinical commissioning group had no contingent assets or liabilities as at 31 March 2016.
NHS England is maintaining the provision for continuing health care cases identified pre 1st April 2013 on its balance sheet.

32 Commitments

32.1 Capital commitments

The clinical commissioning group does not have any capital commitments to disclose (nil in 2014/15).

32.2 Other financial commitments

The clinical commissioning group has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

	2015-16	2014-15
	£000	£000
In not more than one year	225	0
In more than one year but not more than five years	453	0
In more than five years	1,884	0
Total	**2,562**	**0**

There are no other financial commitments where the full cost of the individual scheme exceeds £1m as at 31 March 2016.

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

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

33.1.3 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	Loans and Receivables 2015-16 £000	**Total 2015-16 £000**
Receivables:		
· NHS	498	498
· Non-NHS	298	298
Cash at bank and in hand	13	13
Other financial assets	66	66
Total at 31-March-2016	**875**	**875**

	Loans and Receivables 2014-15 £000	Total 2014-15 £000
Receivables:		
· NHS	43	43
Cash at bank and in hand	2	2
Total at 31-March-2015	**45**	**45**

33.3 Financial liabilities

	Other 2015-16 £000	**Total 2015-16 £000**
Payables:		
· NHS	2,511	2,511
· Non-NHS	9,279	9,279
Total at 31-March-2016	**11,791**	**11,791**

	Other 2014-15 £000	Total 2014-15 £000
Payables:		
· NHS	1,202	1,202
· Non-NHS	9,044	9,044
Total at 31-March-2015	**10,246**	**10,246**

34 Operating segments

The clinical commissioning group considers it has only one segment: commissioning of healthcare services.

35 Pooled budgets

From 1st April 2015 the CCG has entered into pooled budget arrangements in respect of the Better Care Fund (BCF) initiative. This is hosted by Lancashire County Council under Section 75 of the NHS Act 2006. The BCF is designed to create a local single pooled budget to incentivise the NHS and local government to work more closely together around people, placing their well-being as the focus of health and care services.

The unaudited memorandum of account for the pooled budget for the Better Care Fund for 2015-16 identifies income of £89,219k and expenditure of £89,219k, resulting in a net breakeven position. The contribution made by the clinical commissioning group was £10,961k to the fund with £7,281k utilised for CCG commissioned healthcare, representing 12.29% and 8.16% of the total funding. The remainder of the allocation, £3,680k was utilised by Lancashire County Council for Local Authority commissioned schemes, working collaboratively across Lancashire with other Clinical Commissioning Group healthcare partners.

36 NHS Lift investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2016 (nil at 31 March 2015).

37 Related party transactions

Details of related party transactions with individuals are as follows:

Name	Interest	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£000
Ms Mary Dowling	Ms Dowling is a member of the University of Morecambe Bay NHS Foundation Trust (not active).	1,570		229	
	Ms Dowling is a Lay Chair, on the Performers List Decision Panel at NHS England (Lancashire and Greater Manchester Area Team.)	1,034			134
Dr Tony Naughton	Dr Naughton is part owner and GP at Thornton Medical practice, his spouse is also a part owner and GP.	1,396			
	Dr Naughton has a single share interest in Fylde Coast Medical Services; his spouse also has a single share in FCMS.	1,489			
Dr Peter Bennett	Dr Benett was a GP Principal at Clifton Medical Practice up until August 2015.	1,028			
	Dr Benett is Director of Reynolds Benett Ltd.	55			
	Dr Benett has a single share interest in Fylde Coast Medical Services.	1,489			
Dr Kathryn Greenwood	Dr Greenwood is GP Partner at Queensway Surgery.	1,156			
	Dr Greenwood has a single share interest in Fylde Coast Medical Services.	1,489			
Dr Adam Janjua	Dr Janjua is a GP Partner at Fleetwood Surgery which is a member of the Fleetwood Community Care Limited.	636			
	Dr Janjua is Director of Adam Janjua Limited.	51			
Dr Thomas Johnson	Dr Johnson is Director of Carrsfield Medical Limited.	40			
Dr V G Chandrasekar	Dr Chandrasekar is a GP Principle at Beechwood Surgery.	346			
	Dr Chandrasekar is a £1 shareholder in Preston Primary Care Centre (Out of Hours service).	55			
	Dr V G Chandrasekar is an employee of Blackpool Teaching Hospital NHS FT for two sessions per week.	100,601		1,153	
Dr James Reid	Dr Reid is a GP Partner at Ansdell Medical Centre.	1,325			
	Dr Reid's wife is an employee of Lancashire Teaching Hospitals NHS FT.	10,583			110
	Dr Reid has a single share interest in Fylde Coast Medical Services.	1,489			
Dr Felicity Guest	Dr Guest is a GP Partner at Thornton Practice.	1,396			
	Dr Guest's husband is an employee of Lancashire Care NHS Foundation Trust.	17,343		489	60
Dr Jacky Panesar	Dr Panesar was a GP Partner at Ash Tree House Surgery.	1,447			
	Dr Panesar is the Director and 50% shareholder of Delphi Medical Ltd which provides substance misuse and GP services nationally to the NHS.	39			
	Dr Panesar has a single share interest in Preston Primary Care Centre.	55			
Mr Peter Tinson	Mr Tinson's Spouse is an employee of the University Hospitals of Morecambe Bay NHS Trust.	1,570		229	
Mr David Walsh	Mr Walsh has two daughters who are both employed by NHS England.	1,034			134

Please note that the above figures represent the total value of transactions between the clinical commissioning group and the organisations identified as an interest. The values do not represent transactions with the individuals named.

The above table concentrates on the interests and related transactions of the members of the CCG Governing Body only.
Whilst the Members' Council may have declared interests as shown in the Annual Report, it is the Governing Body that has the responsibility for financial decision making in the CCG.

38 Events after the end of the reporting period

The clinical commissioning group did not have any events after the end of the reporting period to disclose that would have a material effect on the 15/16 financial statements.

39 Losses and special payments

The clinical commissioning group had no losses cases during 2015/16 (nil in 2014/15).

40 Third party assets

The clinical commissioning group held no third party assets as at 31 March 2016 (nil at 31 March 2015).

41 Financial performance targets

clinical commissioning group has a number of financial duties under the NHS Act 2006 (as amended).
clinical commissioning group performance against those duties was as follows:

	2015-16 Target	**2015-16 Performance**	2014-15 Target	2014-15 Performance
Expenditure not to exceed income	238,616	234,544	209,412	205,022
Revenue resource use does not exceed the amount specified in Directions	238,283	234,211	208,465	204,075
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	20,189	20,246	0	0
Revenue administration resource use does not exceed the amount specified in Directions	3,577	3,237	3,825	3,619

42 Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2015-16 financial year (nil in 2014/15).

43 Analysis of charitable reserves

The clinical commissioning group had no charitable reserves during 2015/16 (nil in 2014/15).