NHS Blackburn with Darwen Clinical Commissioning Group

Annual Report and Annual Accounts

Annual Report 2015/16

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Foreword

Message from the new Chair and Clinical Chief Officer

During this challenging year, we have made excellent progress in tackling the many issues which affect the health and wellbeing of local people. Our work during the last 12 months is making a real difference to the quality of life of thousands of people and will continue to grow from strength to strength.

We acknowledge that there are more significant challenges ahead for the borough but we believe we have laid the foundations which will enable us to meet those challenges and changes which are facing the NHS both locally and nationally in the coming years.

The developing Healthy Lancashire and Pennine Lancashire Programmes give us a real opportunity to transform the way we work, the way patients are cared for and the way patients take responsibility too for their own care. As with any large change programme, there will be challenges and difficulties but there is a real commitment by everyone involved that this is the way forward.

Our joined up working across health and social care in the four localities is starting to show some real benefits for our patients and communities. Strong neighbourhoods have a critical role to play in improving and sustaining people's health and wellbeing. Strong neighbourhoods can support people to stay in their own homes longer and keep them out of hospital or care homes – it is where most people would prefer to be looked after and we want to strengthen our neighbourhoods further to allow people to lead independent and fulfilling lives. The Better Care Fund provided us with the opportunity to build on this work throughout the last 12 months and in the coming years; we will focus on building resilience within our communities and strengthening our relationships with voluntary and community organisations.

As lead commissioner for CCGs in the county for mental health services (provided by Lancashire Care NHS Foundation Trust), we have worked hard with our partners during some very difficult times to improve outcomes for patients. Tackling mental health is a national issue but we will continue to focus our efforts on ensuring that our patients receive a positive experience of care where they are treated and cared for in a safe environment where they are protected from harm.

We will continue with our plans to gain more influence over Primary Care Services (GPs) as part of our drive to transform service over the coming years.

At a time when the NHS and social care is undergoing tremendous change, engagement is even more important than ever. We are looking at new and improved ways to engage with members of the public and stakeholders. We need them to tell us what services are important to them and how we can work together and smarter to deliver them in a different way, whilst still meeting their needs.
In summary, this year has been a challenging one but has prepared us for the bigger challenges that lie ahead. By working together we shall seek to continually improve the health and wellbeing of the people we serve.

Dr Chris Clayton

Clinical Chief Officer

(Accountable Officer)

Graham Burgess

Chair

Section 1: Performance Report

1.1 Overview

Statement of the Purpose and Activities of the Clinical Commissioning Group

The CCG was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012 (the Act), which amended the NHS Act 2006. The full range of legislative requirements is set out in the CCG's Constitution document which can be accessed here:

http://www.blackburnwithdarwenccg.nhs.uk/us/constitution/

The CCG's constitution describes the governing principles, rules and procedures that the member practices have established to ensure accountability and probity in the day to day running of the organisation and to ensure that the CCG remains true to its mission and delivers its duties under the Act.

The CCG's vision is "to deliver effective, efficient, high quality, safe, integrated care. This will improve the health and wellbeing of the population of Blackburn with Darwen and help people live better for longer, reducing health inequalities and improving outcomes in the borough". The aim for Blackburn with Darwen CCG is to secure better outcomes for patients as defined by the 5 domains of the NHS Outcomes Framework and uphold the pledges in the NHS Constitution.

Our strategic priorities are:

- Prevent people from dying prematurely with a focus on improving cancer outcomes and cardiovascular disease
- Help people to recover from episodes of ill health or following injury; a number of transformational initiatives have been implemented to reduce avoidable hospital admissions, deliver high quality and effective hospital care and improve hospital discharge
- Ensure people have a positive experience of care; a range of measures have been developed to ensure the people of Blackburn with Darwen have a positive experience of care
- Treat and care for people in a safe environment and protecting them from avoidable harm; improving the quality of the care we commission across all providers within the local health economy

In June 2014 the CCG published its Five Year Strategic Plan which set out the CCG's priorities for improving health, reducing health inequalities and supporting the delivery of the NHS Outcome Framework aligned to the health needs of the local population and priorities within the Joint Health and Wellbeing Strategy.

In March 2015 the Health and Wellbeing Board were presented with the CCG's Operating Plan including areas for joint working as outlined in NHS England's 5 Year Forward View. Additionally,

in June, September and December updates were presented to the Health and Wellbeing Board on progress with the Better Care Fund Plan.

A more detailed analysis of the CCG's performance against key performance measures is contained within the performance analysis report.

Statutory Duties

The statutory duties of the CCG are set out within NHS England's "The functions of Clinical Commissioning Groups" (March 2013). The responsibility for discharging our key statutory duties rests with the Governing Body. The governance arrangements for the way in which we manage our statutory duties are outlined within our Constitution.

Duty	Requirement	How this is discharged
14Z15(2)(a):	How the clinical commissioning group has discharged its duties under section 14R (duty as to improvement in quality of services)	The work of the CCG's Quality, Performance and Effectiveness Committee (QPEC) provides assurance to the Governing Body on the development and implementation of the CCG's strategy for continuous quality improvement in the services we commission. Further information on how the CCG discharges this duty and the roles and responsibilities of the QPEC can be found in the Annual Governance Statement (p38)
14Z15(2)(a)	How the clinical commissioning group has discharged its duties under section 14T (duties as to reducing inequalities)	The CCG's annual equality and inclusion report outlines how the CCG has discharged this duty. This is published on the CCG's website. The CCG's strategies, policies and plans are developed in conjunction with Equality Impact and Risk Assessments.
14Z15(2)(a):	How the clinical commissioning group has discharged its duties under section 14Z2 (public involvement and consultation by clinical commissioning groups)	The CCG's Communication and Engagement Strategy sets out our approach to public involvement engagement. The CCG website page "get involved" provides information on how the public can provide feedback through involvement in public participation groups and the CCG's Citizen Panel.
14Z15(2)(b):	The extent to which the clinical commissioning group has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007	The CCG are integral partners within the health and being board, and as such, play a key role in delivering the health and wellbeing strategy. The BwD Health and Wellbeing Strategy was refreshed in 2015, and now takes a life course approach to improving health and wellbeing, with delivery

		groups established to drive forward activities under the Start Well; Live Well and Age Well priorities. The CCG are represented within each of these priority delivery groups and have ensured that each group has input into the development of the annual commissioning intentions. The CCG also play a key role in taking forward some important activities to ensure the achievement of priorities

Throughout the year the CCG has participated in monthly assurance meetings with NHS England to enable an assessment to be made that the CCG is discharging its statutory duties, in accordance with NHS England's CCG Assurance Framework.

Further information on the work of the CCG can be accessed here:

http://www.blackburnwithdarwenccg.nhs.uk/about-us/publications/

Key issues and risks that could affect the CCG deliver its objectives

The CCG has in place a system of internal control that supports the achievement of the organisation's aims and objectives. At the beginning of the financial year, the CCG's Governing Body agreed its corporate objectives aligned to those strategic priorities. The Governing Body then identified the principal risks to those objectives and these are held on the Governing Body Assurance Framework, which is reviewed and monitored throughout the year.

Corporate Objective 2015/16	**Principal Risks**
To extend the life of our citizens and their quality of life by adding life to years as well as years to life	There is a risk that ineffective commissioning decisions will prevent the CCG from achieving its corporate objectives, improving health and reducing inequalities
To ensure there will be no gaps, no duplication - with integrated services and partnership working; including better relationships with voluntary, community and faith sector organisations	System-wide capacity issues may emerge that prevent the delivery of the CCG's plans and priorities is a risk that the Commissioning Support Unit is unable to provide timely and appropriate support to the CCG (this closed in June 2015) Conflicting priorities between partners including East Lancashire CCG, the Local Authority and our providers may result in health and social care commissioning responsibilities not being aligned

To engage and encourage patients and the public to participate in everything we do and the importance of self-care and family wellbeing	There is a risk that insufficient engagement with patients and the public on CCG priorities and service developments may lead to decisions that do not fully meet their needs and could result in a challenge the CCG
To improve services and tackle inequality, evidence best practice to inform decisions and root out poor practice	Inability to secure active participation from member practices for delivering the CCG's plans around primary care at scale Responsibility for co-commissioning primary care must be carried out within the CCG's existing financial resources - failure to manage this effectively may impact on the delivery of existing CCG plans and priorities Current GP workforce capacity may impact plans for future primary care delivery (this was updated to Clinical Workforce Capacity to reflect the wider system issues re workforce capacity) Failure to effectively manage conflicts of interests if CCG is successful in expression of interest to co-commission primary care services with NHS England
To offer effective service interventions which will provide a better experience for patients with privacy and dignity	There is a risk that providers deliver poor quality care and do not meet quality standards and outcomes

Key Developments during 2015/16

This section will provide an overview of the key developments during 2015/16 against each of the following areas:

- Mental Health
- Primary Care
- Integrated Care
- Scheduled Care
- Unscheduled Care
- Children and Adolescent Mental Health Services

Mental Health

Throughout the year the CCG (as lead commissioner for adult mental health in Lancashire) has worked closely with Lancashire Care NHS Foundation Trust (LCFT), to deliver the ambitious plans for a full scale redesign of its crisis mental health pathway and support the delivery of the mental health crisis concordat outcomes. On behalf of the eight Lancashire CCGs, Blackburn with Darwen CCG has also worked closely with LCFT and the Midlands and Lancashire Commissioning Support Unit, (MLCSU) to undertake a Lancashire wide review of the Unscheduled Care (Crisis) pathways within LCFT as part of its planned commissioning intentions.

The Crisis Care Concordat has also enabled strong partnership working across numerous stakeholder organisations in Lancashire including Health and Social Care, Police, North West Ambulance Service (NWAS), the voluntary sector and Criminal Justice Liaison Team. The unique needs of children and young people and people with Learning Disabilities have also been considered and incorporated into the plans.

Various redesign programmes are underway within Blackburn with Darwen and the wider Pennine Lancashire footprint. The services included are:

- Crisis Support Unit (CSU) – is providing a safe non-clinical environment in which people experiencing crisis or pre-crisis and facilitates 'de-escalate', therefore avoiding admittance to Emergency Departments. Due to its initial success a second unit is planned to open in Lancashire during 2016.
- Mental Health Assessment Units – a unit providing clinical assessment for a maximum of three days in order to divert admissions from the Emergency Department and ensure patients are referred into and discharged out of services appropriately.
- Street Triage – Mental Health nurse and police officer working as a team, avoiding unnecessary escalation to a crisis situation and/or attendance at Emergency Departments/136 suites.
- Criminal Justice Liaison (CJL) – providing a seven day service within all the police custody suites, provides direct access to mental health workers for persons who are arrested. All age service - 10yrs upwards.
- Mental Health Helpline / 111 – to be expanded to support and provide advice to Mental Health professionals and other organisations when dealing with people experiencing Mental Health crisis (all age) improving signposting.
- Development of a "data revolution" to inform effective decision making whilst improving transparency and service improvement drives.
- Working with providers to ensure the practice of "Out of Area Treatment" (OATs) to be completely eliminated by 2020/21.
- Vulnerable people Emergency Department Liaison - Ensure that 'Core 24' liaison mental health services are available in acute hospitals across all ages and departments.
- Increase provision of community based services such as residential rehabilitation, supported housing.

The CCG continues to perform well in relation to Improving Access to Psychological Therapies (IAPT). In terms of the access rates, the CCG has performed above its year to date target, and, through the additional activity commissioned through the voluntary sector has resulted in Blackburn with Darwen achieving some of the top access rates in the North of England.

In terms of recovery rates, both locally and nationally there has been a history of below target performance however, improvement has been seen during 2015/16. It is also anticipated that new national targets for IAPT and Early Intervention in Psychosis will be met once they come into effect in April 2016.

The development of Primary Care Mental Health Services is at the heart of the ongoing work in Blackburn with Darwen and the wider work across Pennine Lancashire and will include a fully integrated Health and Wellbeing offer to manage the needs of people with both, mental health and long term physical health issues. In 2015/16 the "Dementia Case for Change" across Lancashire has delivered significant benefits, including the successful opening of the Dementia/ Advanced Care wards and implementation of specialist community dementia teams. Significant progress has also been made in achieving early diagnosis in Pennine Lancashire, which is well above the national average.

Future Priorities

To complement the Lancashire and Cumbria Sustainability Transformation Plans (STP), Local Delivery Plans (LDP) are being developed across Pennine Lancashire including:

- Integrated Mental Health and Wellbeing Offer including improved management of people experiencing Long Term Conditions (LTC) e.g. Diabetes, COPD, Stroke
- Redevelopment of IAPT Services (workforce challenges and skill mix)
- Integrated Acute liaison and discharge services including vulnerable adults, frail elderly and young people
- Primary Care teams to deliver Shared Care for people with Mental Health Problems
- Closer Integration of Dementia Teams into Local Frailty Pathways.
- Ensuring that the care and treatment of people with dementia is central to the newly emerging frailty pathway in Pennine Lancs.

Primary Care

The CCG was successful in its application to take on fully delegated responsibility for commissioning Primary Care (General Practice) across Blackburn with Darwen and this arrangement commenced on 1st April 2015. This has allowed the CCG to set up robust governance structures in determining and implementing the primary care strategy which will positively impact on patient's care going into the future.

Critical to implementing the improvements the CCG has developed an innovative new local improvement contract for General practice which will commence on 1st April 2016. All Blackburn with Darwen practices are signed up to the local contract and the CCG are positive about the changes that the new contract will start to bring about in 2016/17.

The four localities (Blackburn North, East, West and Darwen) are now operational and are bringing quality benefits for patients; this is being done by specialisation through extended primary care teams

For patients this means:

- access to the care they need closer to home
- access to high quality acute primary care both in and out of hours
- early diagnosis and systematic care planning
- high quality and consistent care

Blackburn with Darwen patients now have extended access up until 8pm Monday to Friday and at weekends. This new service provides over 250 additional appointments per week for patients who find it difficult to access primary care during core times. These additional services are being delivered via the Prime Ministers Challenge Fund /GP Access Fund. The CCG is working closely with the provider to help ensure the sustainability of the services going forward.

Workforce

The CCG have identified clinical workforce capacity as one of its highest strategic risks and as such are working collaboratively with partners across Pennine Lancashire and with Health Education England in the North West to ensure that workforce development is prioritised and actions are taken in order to create a sustainable Primary Care workforce for the future.

The CCG are proud to be one of the first CCGs to take part in the Physician's Associate Pilot Programme, with three practices in the borough taking part in the pilot. Physician Associate's will alleviate some workload pressures from GPs as they will be able to consult certain patients autonomously once fully trained. This is an exciting step for the CCG, with the first cohort of students commencing placements in practice during Spring 2016.

Estates and Infrastructure

The CCG recognises that major service change and delivery will require appropriate high quality estate and supportive infrastructure including IT services and data sharing agreements. A number of estates solutions are currently under consideration and these are aligned to the CCG's plans for integrated locality teams and developing the General Practice estate to be able to effectively deliver future services.

Future Priorities

The CCG will continue to focus on improving outcomes for patients by working with practices as they embark on the new local improvement contract. The new local contract and ongoing workforce initiatives will also assist in creating a sustainable Primary Care workforce for the future and the work will continue into 2016/17 and beyond.

Integrated Care and Better Care Fund Development

A range of health, social care professionals and the voluntary sector have been working together in a new improved way to provide a better service for our residents. This way of working jointly and in a co-ordinated way is called Integrated Care. The Better Care Fund budget is aimed at supporting the CCG to bring in new ways of integrated working. Patients are already seeing the benefits of this work. We have been involving patients, carers and other stakeholders in the development of our plans to join together health and social care. The CCG is fully committed to improving how we work together for the benefit of patients and their families and carers.

Keeping people out of hospital

The CCG has worked to bring GPs, community nursing teams, social care and voluntary sector organisations together to provide better care, closer to home for patients. This will keep people independent and healthy for longer. It will prevent unnecessary stays in hospital and give patients and their families more confidence in how their health and care needs are managed in the community.

We are continuing to work with the voluntary sector to ensure that people are seen earlier and support is provided when they need it so problems do not escalate. To improve access to support in neighbourhoods, we have joined up information, advice and guidance services. This means that patients will have one assessment and their care will be more co-ordinated. The aim is for people to regain independence and confidence to live comfortable and safely at home.

The new way of working is aimed at improving the quality of life for patients with support needs and their carers. The new service will increase the number of unpaid and informal carers who receive an assessment and are given a personalised support plan. This will allow smoother transition from young

carer's services to adult carer's services and will be better linked with wider voluntary sector services, reducing duplication and increase the number of people accessing the service.

When people require more intensive support in the community, in order to prevent a hospital admission, we have developed a new joined up way of working involving GPs, community nursing, therapy and social care colleagues to support patients in their own homes. This service is supported by a central support team which can provide signposting quickly, if necessary, to more than 800 out of hospital services. Plans are now in place to proactively identify patients at risk of hospital admission and manage their care in the community.

Memory assessment services are now offering scheduled appointments in designated GP surgeries across Blackburn with Darwen and are working to improve access to, and the quality of, services offered to patients living with dementia. Across the borough, there are currently 72 dementia champions compared with 17 in September 2014 and 2,802 dementia friends compared to 471 in September 2014. Dementia awareness sessions are being delivered regularly to professionals, individuals and organisations including residential homes. Businesses and GP Practices are becoming recognised as dementia friendly organisations.

We are working with the Council's Decent and Safe Homes (DASH) service on housing improvements that will improve the living conditions of residents that impact on their health.

Getting home sooner

Reducing the amount of time people spend avoidably in hospital, reducing delays in transfer of care from hospital, and inappropriate admissions of older people into residential care have been key areas of activity throughout the year. An Integrated Discharge Service was launched in September 2015 and there is additional health and social care capacity in the community to support seven day discharge.

We have reviewed care provision for patients who are not yet ready to go home but can be released from hospital. The main priority is to return patients to their own homes where they can be cared for while they recuperate. The Age UK 'Here to Help' Integrated Care Programme targets patients with two or more long term conditions and who have experienced at least two emergency admissions in a 12 month period or meet other high risk criteria; it also proactively targets patients awaiting discharge. The programme has worked alongside health and social care services in the community, providing voluntary support through working as part of local teams.

Future Priorities

Blackburn with Darwen is now looking at how it can further join up services across Pennine Lancashire and provide a consistent out of hospital offer to support residents across a wider area, whilst ensuing that local teams and GPs receive the support they need to look after their communities.

Scheduled Care Development

The CCG's strategy and vision for the delivery of Scheduled (elective) Care is to see a significant shift in delivery of care from the acute sector to primary/community care.

The Clinical Scheduled Care Strategy 2014-2019 provides an overview of the CCG's aims and objectives for planned care and how this will be achieved. A key element of the strategic approach is the redesign and commissioning of sustainable services for the longer term, with a focus on improving patient outcomes and experiences delivered within the community setting. This strategy will support decision-making within the CCG; it also underpins the Scheduled Care commissioning intentions and direction for the next three years.

During the reporting period the CCG started a programme of pathway service redesign with a planned reduction on non-specialist referrals to secondary care for patients with specific clinical conditions being managed in an alternative setting (e.g. community service) via a single point of access. This benefits patients, who are getting the right care at the right time and do not need to travel to hospital for an appointment, frees up the specialists in the hospital to see the urgent or more complex conditions and results in patients across all sectors being seen in a timely manner, in the most cost effective way.

This work has been undertaken with local acute and community providers including East Lancashire Hospital Trust, Intermediate Skin Services and Lancashire Care Foundation Trust. The aim of the service redesign is to shift activity for high volume specialties which are clinically appropriate to be delivered in primary/community settings. Service redesign is being undertaken in Diagnostics, Dermatology, Ophthalmology, Anti-coagulation and Musculoskeletal services. A key outcome of this area of work is to ensure that services delivered are of high quality, safe and provide a positive patient experience measured through local patient experience surveys. The CCG is promoting local pathways and GP-led services as an alternative to secondary care (where clinically appropriate) via the new GP Intranet, CCG Website and newsletters. Examples of the service redesign work are summarised below.

Integrated Eye Service

The new Integrated Eye Service was launched on 5th October 2015 and has been a successful multiple provider and commissioner service redesign project which has created a new integrated eye care pathway and service. The service is managed by East Lancashire Hospitals NHS Trust and delivered by the Integrated Eye Team which includes, Local Optical Committee, Pennine Lancashire Eye Care Limited (local Optometrists) and GP with Special Interest (GPwSI), based in the community. The new service provides a wider range of services to support patients with a number of eye conditions including minor eye conditions, cataract screening, low vision aids, age related macular degeneration (dry). The eye care pathway has been developed to streamline patients into the most appropriate level of care dependant on the patient needs without requiring a referral from their GP. Where possible and clinically appropriate patients can be signposted and managed within the community setting either via local Optometrists or the GPwSI to ensure the patient is seen at the right time, right place.

Integrated MSK /Service

The Integrated MSK (Musculoskeletal), Pain and Rheumatology service was launched on 6th July 2015 managed by East Lancashire Hospitals NHS Trust. This complex service redesign of MSK, Rheumatology and Pain Management services was undertaken to integrate the patient pathways and therefore provide a better patient experience managed by a Single Point of Access triage system. The improvements to the pathway ensure that patients' needs are met within the community setting, patients seen at the right speciality at the right time delivered through a mixed professional workforce including nurses, GPwSI's and physiotherapy. The service has recently won the prestigious British Society for Rheumatology Best Practice Award in the category of 'Service Configuration and Pathways'.

The CCG will continue to work collaboratively with all providers to ensure that the local population receive responsive and needs led services who meet their waiting time targets and provides the best outcomes as close to home as possible.

Future Priorities

The CCG is now looking at different ways of understanding demand with Primary Care and Community Services and will be introducing demand management tools in 2016. A further dimension to this approach will be the review of key services and procedures to ensure that they are commissioned in line with best practice and evidenced-based medicine. Only procedures which are proven to add value to an individual will be commissioned. This is to ensure that benefits to patients are proportional to risk and also to ensure the most efficient use of the limited commissioning resources available.

Unscheduled Care

Acute Medical Care

East Lancashire Hospitals NHS Trust has changed the model of care for those patients presenting with acute medical conditions. To ensure effective patient flow through the winter period the 'Medical Assessment Unit' has now become the 'Acute Medical Unit' which supports safe, personal and effective patient care and flow all year round.

The unit expanded to 64 beds in October 2015 which features a 12-16 hour assessment and up to 72 hour short stay. The operating principles are based on the Royal College of Physicians 'Future Hospital' guidance and the expected benefits are centred on improved patient care. The Unit provides a team of experienced healthcare professionals who are dedicated to providing rapid assessment of the problem, organising the right investigations and making the right decisions so patients can start recovery as soon as possible.

Since opening in October the unit has dealt with 12,340 patients of whom 45% are discharged within 72 hours and an increased number of patients received ambulatory care. The unit has improved the patient experience with reduced bed moves and length of stay which has been evidenced with the results from the friends and family test.

Integrated Discharge Service

The Integrated Discharge Service is a single team, providing a multidisciplinary person-centred process around discharging patients from hospital. The team are based at Royal Blackburn Hospital and represent a truly integrated service, made up of clinical, therapeutic and social care staff. This means that patients leaving the hospital setting receive a timely assessment and a safe, comprehensive

discharge process, supporting them to move to their next place of care in a dignified way and in a way that promotes achieving the best outcomes possible. The service offers discharge, re-admission and complex case management as needed, along with a local navigation function and streamlined referral processes.

The service aims to reduce delays in discharges of patients from hospital, in addition to realising a whole host of other benefits such as reduction in the number of inappropriate admissions to residential care, preventing re-admissions to hospital, providing assessment and meeting of care needs as close to home as possible, improved relationships and communication with key services and departments to support effective, seamless patient pathways, better management of patient flow, and most importantly, an improved patient experience and better health outcomes.

Since the teams launch in October 2015 the CCG and partners have been working together to analyse the activity and impact so far, seeing positive results particularly around patient experience and delays in discharges.

Front Door Team

The 'Front Door Team' is based at Royal Blackburn Hospital Emergency Department. The team are comprised of colleagues from health and social care, therapies, and third sector offering a blended, multidisciplinary function including navigation, rapid response, see and treat, and true deflection from acute emergency services. The service was developed collaboratively and commenced in December 2015, a solution to mitigating the impact of winter pressures on the hospital and wider care system and a mechanism for developing integrated working within the health and social care system. Ultimately, the service represents a true opportunity to allow patients to receive the right care in the right setting. Whilst work is ongoing to review the preliminary phase of the Front Door team with particular focus on service improvement and enhanced integration, already the team are showing positive early results with an estimated deflection rate of 32% for referrals to the Emergency Department and only 25% of those patients referred to the service being admitted. Referrals to the service have mainly been for patients aged 81+ and for reasons relating to respiratory or pain symptoms; for these patients especially, not being admitted to hospital unnecessarily is critical for better health outcomes and so this team provide a vital service.

Falls Response Service

The service involves therapy staff from ELHT working together with NWAS paramedics to provide a timely response and intervention service for patients who have fallen and dialled 999.

The service aims to reduce the number of older people conveyed by NWAS emergency vehicles to the Emergency Department following a fall, by supporting people to remain in their own home with immediate and/or longer term intervention from the Falls Response Service (FRS) and/or other support services. The therapists in the FRS are providing the emergency therapy response to the patient following the incident with actions for their safety and adequate care and/or support.

Future Priorities

- To develop a model of clinical and medical support that moves Pennine Lancashire towards the delivery of a revised out of hospital system in line with the requirements of the national urgent care review

Paramedic at Home

- To ensure more patients will be appropriately dealt with at home by paramedics
- To ensure clinically appropriate response by ambulance to 999 calls

Urgent and emergency care centres

- To create an urgent and emergency care system that will deliver the right care, first time for the majority of patients through a networked model seven days a week and which is easy for patients to navigate and understand. This will be implemented via a national service specification that will ensure consistency across all Urgent Care Centres

Emergency centre and Specialised Services

- To ensure timely discharge of patients from hospital to avoid long stays
- To support patients choice and improving hospital discharge into the care sector

Pathway redesign

- To implement a phased programme of work for Chronic Obstructive Pulmonary Disease (COPD)

Children and Adolescent Mental Health Services (CAMHS)

Paediatric Care

A local priority for Paediatric Care is to reduce unnecessary admissions and attendance at A&E for children and young people. There is local evidence to show that often children are admitted to hospital for a short stay of 2 hours or under. This has perpetuated a movement to offer greater intermediate care to support GPs in management of Paediatric Acute cases closer to home. Intermediate services include:

- Clinics where GPs can speak to a Paediatrician for advice and book them into an outpatient clinic the next day
- Children's Community Step-up Service offering paediatric nursing care and assessment in the home seven days per week
- Respiratory Nursing service to offer education and support to encourage self-management of care of asthma and viral induced wheeze

Future Priorities

In 2016/17 priority will be given to:

- Improving care pathways through a single point of access to the above intermediate services
- Reducing respiratory related admissions to the England average through a local action plan based on national recommendations for asthma management
- Dedicated Paediatric Hub at the 'front door' of Urgent Care
- Reducing alcohol related admissions for under-18s in partnership with Public Health

- Integrating treatment pathways from Hospital back to Primary Care
- Hub and Spoke model with dedicated children's GP appointments that offer appointment into early evening. This will support primary care 'overflow' and increase capacity and the likelihood that families can get an appointment to see a GP

Maternity Services

In line with the Five Year Forward View, local Maternity Services have been delivered across a range of settings including the choice of giving birth from a Midwife-Led Unit to support, where possible, a normal delivery with reduced clinical intervention. This has promoted positive feedback and outcomes for local families, with a caesarean section rate which is lower than the national average.

Work has also been undertaken to promote service improvement for perinatal mental health. A project group revealed women felt down in the antenatal stages of care and there was little co-ordination/leadership within the Midwifery service to gain help. Funding from the CAMHS Transformation allocation has been provided to Midwifery services to review current practice and make recommendations going forward for service improvement. Dedicated funding for perinatal mental health is expected to be allocated in 2016/17.

The CCG is keen to improve outcomes around stillbirth and bereavement care. A quality initiative was implemented in 2015/16 based on the NHS England Care Bundle 'Saving Babies Lives'. This proposes four quality improvement measures that will make impact on stillbirth rates;

- Intrapartum Care
- Smoking in Pregnancy Action Plan
- Reduced Foetal Movements
- Growth scanning for babies small for gestational age

A part-time Bereavement Midwife has been appointed to improve care pathways and long-term outcomes for families who have experienced a loss.

Recommendations of the National Maternity Review (published February 2016) will be considered by the Pennine Lancashire Maternity Service Liaison Committee.

Performance Analysis

Monitoring of the key performance indicators for health services is one of our most important ways of making sure that the most critical services are performing properly and taking action with providers of services to make improvements where targets are not met.

The highest priority areas which we monitor are:

- Operational standards for treating people in A & E
- Response times for ambulances to emergencies
- Waiting times for cancer diagnosis and treatment
- Waiting times for planned treatment, such as orthopaedic surgery 18 week Referral To Treatment targets (RTT)

The following table shows the latest performance information available at the time of writing.

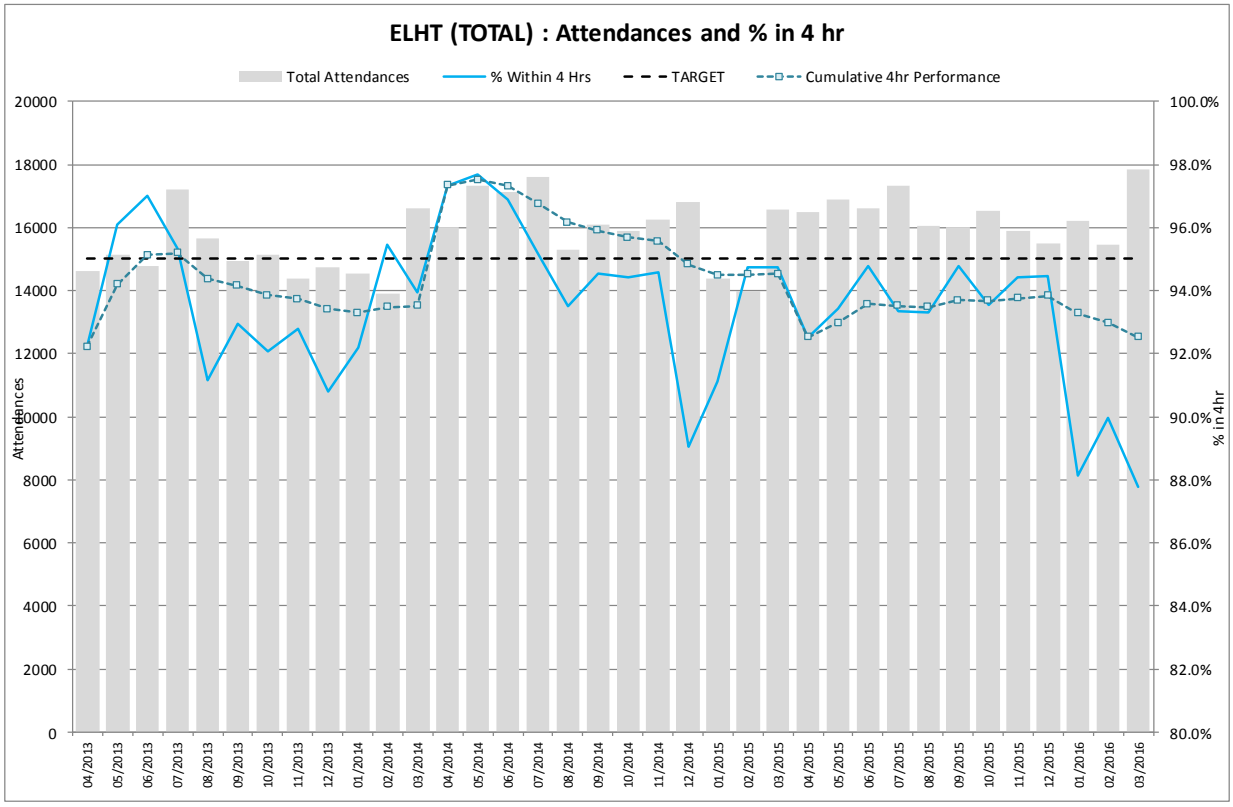
Performance Analysis 2015/16 (as at February 2016)

Metric	Level	Target	Blackburn with Darwen CCG 2015/16 YTD (as at Feb 2016)
NHS Constitution measures			
Referral To Treatment waiting times for non-urgent consultant-led treatment			
61: Referral to Treatment RTT (Adjusted Admitted)	CCG	90.00%	No longer published
62: Referral to Treatment RTT (Non-Admitted)	CCG	95.00%	96.47%
1291: Referral to Treatment RTT (Incomplete)	CCG	92.00%	95.50%
Diagnostic test waiting times			
1828: % of patients waiting 6 weeks or more for a diagnosic test	CCG	1.00%	0.34%
A&E waits			
431: 4-Hour A&E Waiting Time Target (Monthly Aggregate For Total Provider)	ELHT	95.00%	93.09%
Cancer waits – 2 week wait			
17: % of patients seen within 2 weeks for an urgent referral for breast symptoms (MONTHLY)	CCG	93.00%	95.87%
191: % Patients seen within two weeks for an urgent GP referral for suspected cancer (MONTHLY)	CCG	93.00%	96.49%
Cancer waits – 31 days			
25: % of patients receiving subsequent treatment for cancer within 31 days (Radiotherapy Treatments) (MONTHLY)	CCG	94.00%	97.64%
26: % of patients receiving subsequent treatment for cancer within 31 days (Surgery) (MONTHLY)	CCG	94.00%	96.52%
535: % of patients receiving definitive treatment within 1 month of a cancer diagnosis (MONTHLY)	CCG	96.00%	99.35%
1170: % of patients receiving subsequent treatment for cancer within 31 days (Drug Treatments) (MONTHLY)	CCG	98.00%	99.39%
Cancer waits – 62 days			
539: % of patients receiving 1st definitive treatment for cancer within 2 months (62 days) (MONTHLY)	CCG	85.00%	87.25%
540: % of patients receiving treatment for cancer within 62 days from an NHS Cancer Screening Service (MONTHLY)	CCG	90.00%	92.86%
541: % of patients receiving treatment for cancer within 62 days upgrade their priority (MONTHLY)	CCG		96.00%
Category A ambulance calls			
546: Category A calls responded to within 19 minutes	NWAS	95.00%	93.18%
546: Category A calls responded to within 19 minutes	CCG	95.00%	94.70%
1887: Category A Calls Response Time (Red1)	NWAS	75.00%	75.55%
1887: Category A Calls Response Time (Red1)	CCG	75.00%	76.25%
1889: Category A (Red 2) 8 Minute Response Time	NWAS	75.00%	71.56%
1889: Category A (Red 2) 8 Minute Response Time	CCG	75.00%	74.85%

- **A&E Waiting Times**

Performance against the operational standard that 95% of patients that attend A&E must be treated, and admitted or discharged within 4 hours of arrival at the department has been performing below target during the 2015/16 reporting period for ELHT (total provider performance, not just BwD specific). Breach analysis reports highlight a number of contributory factors including:

- an increasingly frail and ageing population with more complex needs
- increasing demand particularly around urgent care rather than emergency need (driven by increasing use of 111, perceptions on availability or patient choice around urgent Primary care access)
- surges in demand at specific times
- attendances which could have been dealt with in a more appropriate setting
- problems around system flow, influenced particularly by delayed transfers of care and seasonal variation in bed capacity.



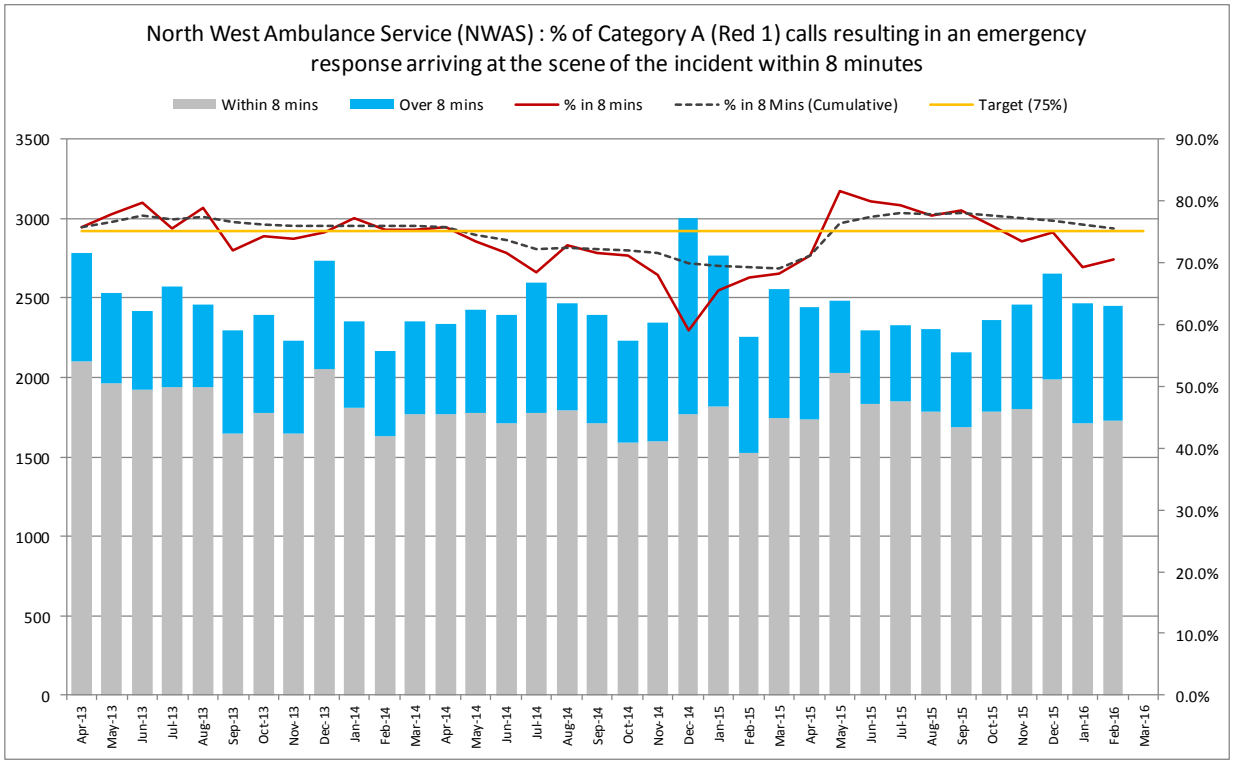
Whilst this is disappointing, it reflects a national position, against which many trusts have struggled to achieve the target particularly over the winter period. To support improvement within ELHT, a number of schemes have been put in place using annual resilience funding from CCGs. The impact of these initiatives has been monitored through the Pennine Lancashire System Resilience Group. Daily and weekly teleconference calls have been held between ELHT, NHS England's Local Area Team, East Lancashire CCG (the lead commissioner), and Blackburn with Darwen CCG. Intense focus and support has been on delayed transfers of care, simple discharge initiatives and through supporting collaborative working in relation to ambulance turn- around times to improve flow through the hospital. Colleagues from across the health and social care economy have also worked with the trust in a number of multi-disciplinary accelerated discharge events (MADE) through the winter period. Despite these efforts, this operational standard has not be met for 2015/16.

- **Response Times for Ambulances to Emergencies**

North West Ambulance Service's (NWAS) overall performance against the national response time targets was not achieved during 2015/16. Targets are classified as follows:

- Red 1 : Immediately life threatening – 75% to be responded to in 8 minutes [Red 1] / 95% to be responded to in 19 minutes
- Red 2 : Life threatening but less critical – 75% to be responded to in 8 minutes [Red 2]

Red 1 and Red 2 targets at a Blackburn with Darwen level performed better than the NWAS average and locally the year-end target was achieved for Red 1. However the CCG is monitored against the overall NWAS performance and therefore targets were not achieved. The service has experienced some increases in activity during 2015/16 particularly in the Red 2 category, although overall activity is down. Locally, the Pennine Lancashire Urgent Care System has implemented a number of actions to support the delivery of Red 1 and Red 2 targets including annual resilience schemes funded by NHS England. These have resulted in additional staff and vehicles being deployed across Pennine Lancashire. Schemes such as Ambulance Liaison Officers working in the Emergency Department to improve ambulance turnaround times, an innovative falls response service and a 'see and treat' vehicle have all been developed and implemented over the past twelve months. A recovery work programme continues to be developed linking NWAS, ELHT, commissioners and other stakeholders.



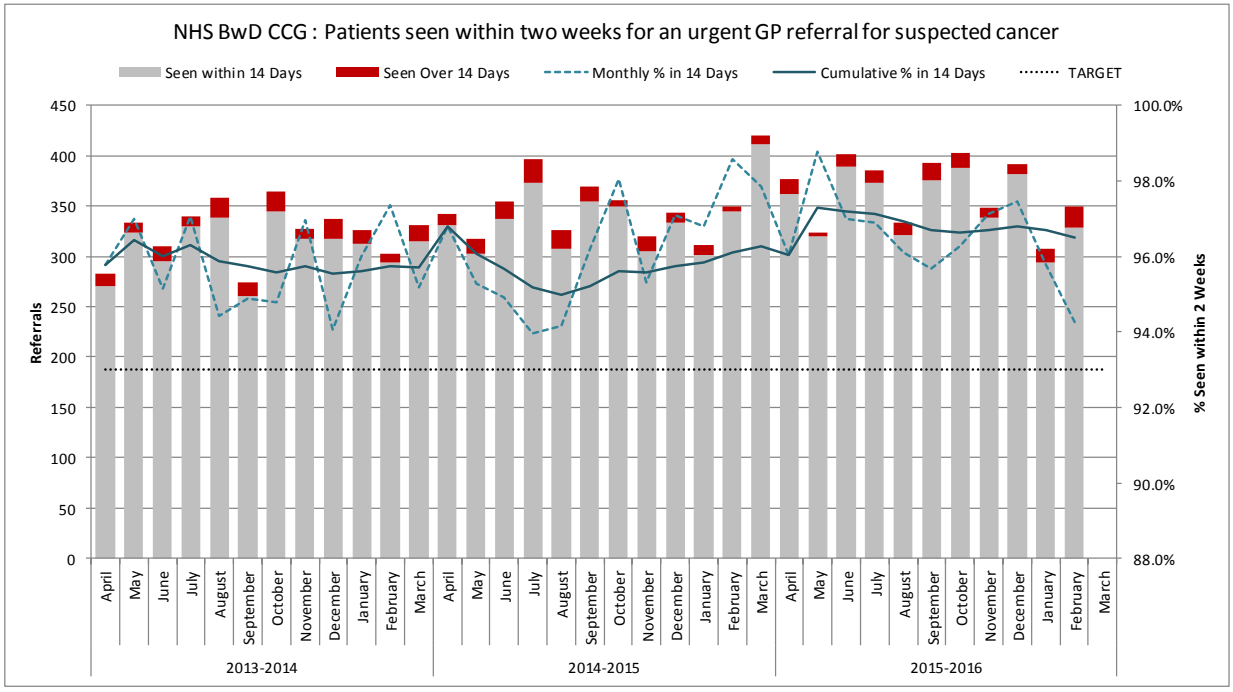
- **Waiting times for cancer diagnosis and treatment.**

Achievement of National Cancer Waiting Time (CWT) standards is considered by patients and the public to be an indicator of the quality of cancer diagnosis, treatment and care NHS organisations deliver. In addition, “Improving and Sustaining Cancer Performance” identified 8 key priorities for local health systems to implement as a matter of urgency. All providers, including ELHT, have completed a self-assessment of compliance against these, and have now been signed off as compliant.

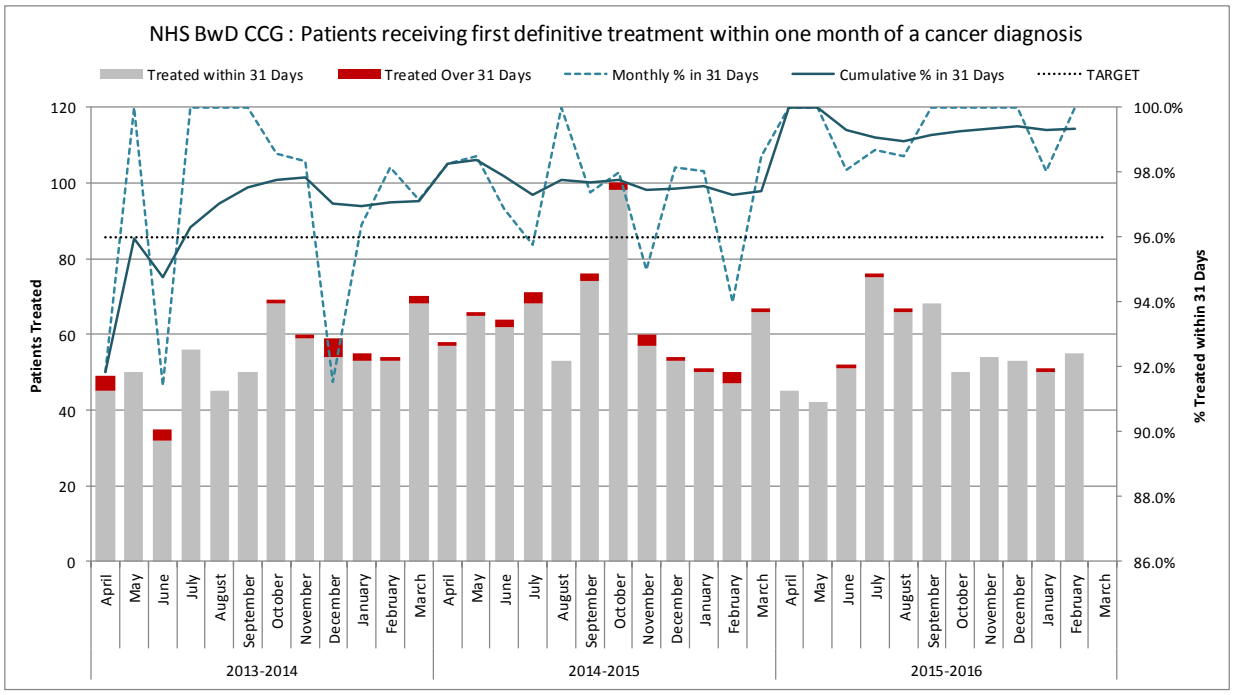
Monitoring of cancer waiting time standards continues to take place on a monthly basis and commissioner and provider teams undertake clinical reviews of any breaches to see if there are any underlying themes that need to be addressed. Key themes identified include elements associated with patient choice and capacity issues across pathways, in particular in relation to diagnostics. There is a continued focus through the Pennine Lancashire Cancer Waiting Time Business Assurance Plan on improving performance against all cancer waiting time targets. Progress is monitored through the Pennine Lancashire Cancer Tactical Group which is accountable to the Pennine Lancashire Operational Resilience Group .

At the time of writing, all Cancer Waiting Time targets are being met overall across the year, although there have been occasional months where performance has fallen below the relevant threshold. Longer term trends showing performance against the three key targets are shown below:

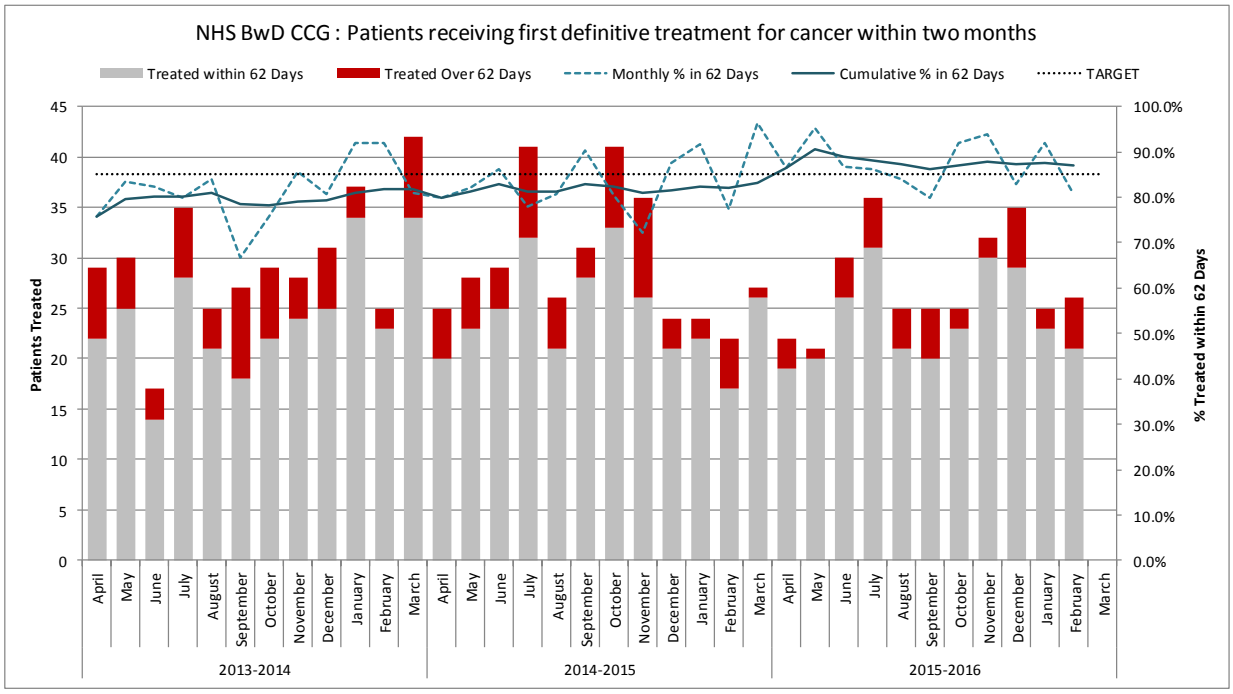
- 14 day referral to treatment



- 31 day diagnosis to first definitive treatment



- 62 day referral to first definitive treatment target

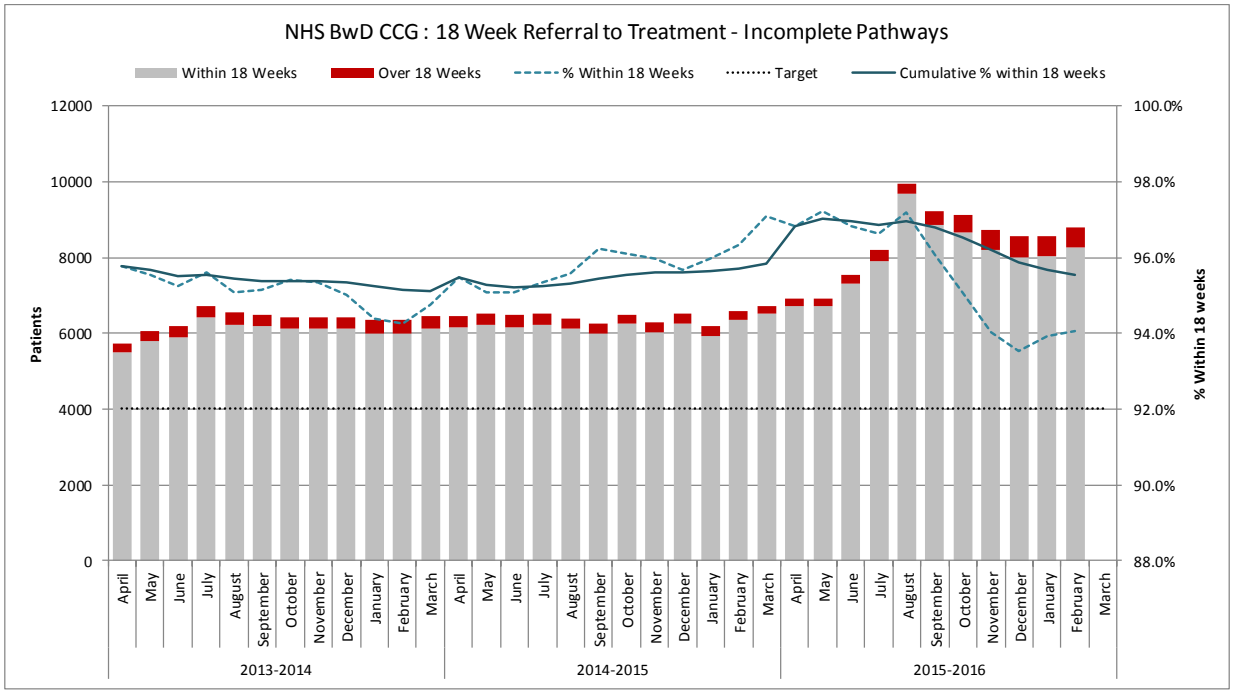


- **18 Week Referral to Treatment Targets**

The NHS Constitution sets out the right for patients to start their non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they wait longer.

During 2015-16, the 18 week Referral to Treatment (RTT) rules were updated and clear emphasis was placed on the importance of the 'incomplete standard' – this is the standard which captures and

reports on every patient who is currently waiting for treatment. The national target for this measure is that 92% of all patients should be waiting 18 weeks or less. Blackburn with Darwen CCG has performed above this threshold during 2015-16 on an individual month and cumulative basis.



Sustainable Development

Measuring, monitoring and reporting on sustainability through this annual report supports the assurance process for meeting legal, reputational and policy requirements. As a commissioner of services the CCG is required to demonstrate its commitment to promoting environmental and social sustainability as a corporate body.

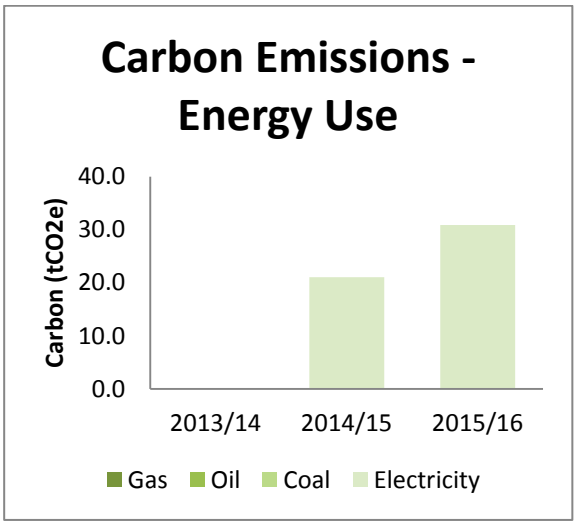
The CCG operates from leased, multi-occupancy premises which benefits from a range of energy reducing features: the heating and cooling system has a variable refrigerant flow (VRF) which is charged with refrigerant R410A, a non-ozone depleting refrigerant. Automatic movement sensors are installed throughout the open plan office space which reduces energy consumption through lights being left on, when an area is not in use. Staff are regularly reminded to power off PCs and other electrical equipment at the end of the working day, or when not in use. The CCG has communicated to all staff the importance of conserving energy for example in reducing the volume of printing and photocopying which in turn saves on costs.

The CCG has utilised the NHS Sustainable Development Unit's (SDU) 'Guide to Sustainable Commissioning for Clinical Commissioning Groups' developed in conjunction with the Royal College of General Practitioners, to help the CCG establish commissioning structures and processes that will deliver business profitability, longevity and resilience in a rapidly changing world.

Goods and Services Spend Profile	2015/16 (£000)
Business services	3,494
Construction	0
Food and catering	3
Freight transport	0
Information and communication technologies	415
Manufactured fuels chemicals and gases	0
Medical Instruments /equipment	0
Other manufactured products	0
Other procurement	63
Paper products	36
Pharmaceuticals	28,187
Travel	40
Commissioning	206,385

- **Energy Reduction**

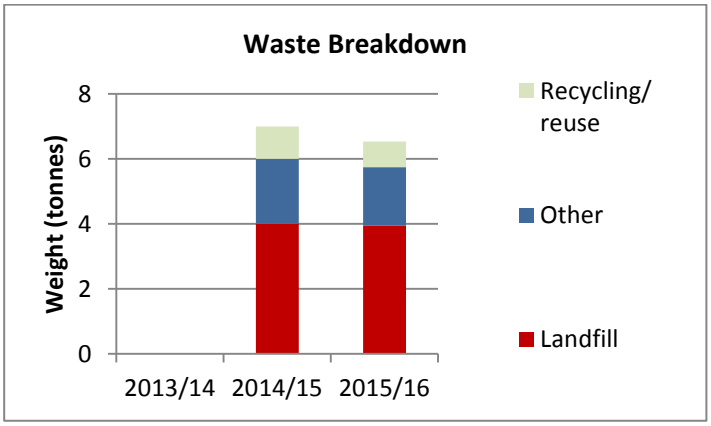
Energy usage contributes towards 15% of the overall health and social care carbon footprint, so reducing energy usage is almost always cost effective and contributes towards reducing emissions, energy bills and demand. Based on the information available the CCG is now able to monitor energy use and carbon emissions to support this reduction.



Proportions of Carbon Footprint by Category	% CO_2e
Energy	97%
Travel	0%
Procurement	3%
Commissioning	0%

- **Waste Reduction**

The CCG has been provided with detailed information relating to the amount of general waste sent to landfill including the amount of waste that is recycled for 2015/16. This information will support the continuing development of the sustainable development management plan and set targets to reduce the levels of waste produced.



- **Travel and transport**

Travel and transport is another major contributor (13%) of the overall health and social care carbon footprint) which includes staff travel to work, and travel between sites for meeting attendance. The CCG is committed to reducing unnecessary levels of travel through encouraging and providing equipment for teleconference calls. During 2015/16 the CCG has made greater use of its IT/video-conferencing equipment, to contribute further to reducing business travelsts. This will also contribute towards reducing pollution on the environment.

- **Contracting and Procurement and Social Value**

Procurement is the largest contributor to the overall health and social care carbon footprint (72%). The CCG is committed to commissioning sustainable models of clinical care through innovative commissioning and procurement. The NHS standard contract (service conditions) requires all providers to take reasonable steps to minimise their adverse impact on the environment, and demonstrate progress on climate change adaptation, mitigation and sustainable development including performance against carbon reduction.

- **Social Value**

The Social Value Act became law on the 8th March 2012, the significance being that all public bodies in England and Wales are required to consider how the services they commission and procure could improve the economic, social and environmental well-being of the area. Social value involves looking beyond the price of each individual contract and considering what the collective benefit to a community is when a public body chooses to award a contract. Blackburn with Darwen CCG is part of a Local Strategic Partnership which is working together to address social values in Blackburn with Darwen including:

- The development of a collaborative on-line portal used to signpost potential suppliers to all tender opportunities within the local public sector
- Creation of a Supplier Registration System which can be used when partners are seeking services for lower value contracts
- Adopting a transparent and consistent approach to identifying and monitoring spend within the borough

- Providing training and mentoring to up-skill and increase the competitiveness of local suppliers
- Standardising the procurement documentation across the Local Public Service Board organisations

On-going commitment will be required to achieve the goals for reducing our environmental impact, improving the natural environment and increasing our readiness for changing times and climates through strengthening social cohesion. To help achieve this, the CCG has completed the Good Corporate Citizen self-assessment survey; the results of the survey will be used to plan and monitor targeted action where the carbon footprint is high and achieve further improvements for sustainable development in commissioning.

Equality and Inclusion

Blackburn with Darwen CCG believes that equality and inclusion includes addressing health inequalities and should be embedded into all our commissioning activity. One of our strategic aims is to provide equality of opportunity to all our patients, their families and carers and to proactively eliminate direct or indirect discrimination of any kind.

The CCG is keen to involve local people in the continuing development and monitoring of our Equality Objectives and strategy to ensure that we commission the right health care services, provide well trained staff to deliver them and ensure our providers meet the equality duties set out in the Equality Act 2010 and promote people's rights.

A key function that enables Blackburn with Darwen CCG to make commissioning decisions and monitor the performance of our providers is to demonstrate that the needs of the nine protected equality groups have been considered in:

- Commissioning processes
- Consultation and engagement
- Procurement functions
- Contract specifications
- Quality contract and performance schedules, and
- Governance Systems
- Policies and procedures

We will continue to work internally and in partnership with our Providers, community and voluntary sector and other key organisations to ensure that we advance equality of opportunity and meet our exacting requirements of the Equality Act 2010.

The CCG published its third Equality and Inclusion Annual Report in March 2016, which sets out how the CCG has demonstrated 'due regard' to the public sector equality duty's three aims in 2015/16 and provided evidence for meeting the specific equality duty, which requires all public sector organisations to publish their equality information annually. Link to Equality and Inclusion Annual Report 2015/16 http://www.blackburnwithdarwenccg.nhs.uk/wp-content/uploads/sites/12/2016/03/BWD-CCG-Equality-Inclusion-Annual-Report-2015_16-Final.pdf

Financial Review of CCG Business 2015/16

The five year financial plan and budgets for 2015/16 were approved by the Clinical Commissioning Group (CCG) at its Governing Body meeting in March 2015.

Revenue resources available to the CCG in 2015/16 were £241.9m including a running cost allocation of £3.5m. The CCG received an allocation increase in 2015-16 of 3.6% but remained 1.68% under its target allocation.

One of the statutory responsibilities for the CCG is for its expenditure not to exceed its agreed revenue resource limit. In 2015/16, the CCG was given a target surplus of 1% of its allocation by NHS England ie £2.1m. In 2015/16, the CCG achieved a surplus of £1.58m which, whilst under the target surplus set, meant the CCG did achieve its statutory financial responsibility of not exceeding its agreed revenue resource limit. The CCG also managed to keep its expenditure within its running cost allocation of £3.5m. There were significant demands on CCG resources during 2015/16, the main areas being the Better Care Fund, health economy financial pressures following the 2015/16 tariff and activity growth throughout the acute sector. During 2015-16, the CCG was required to contribute £10.8m into a pooled budget for the Better Care Fund. This funding has been spent in partnership with Blackburn with Darwen Borough Council under a section 75 agreement. From 1st April 2015, NHS England delegated full responsibility to the CCG for Primary Care Co-Commissioning for the commissioning of GP services and received funding of £20.8m. During 2015/16, the CCG became responsible for the commissioning of Specialist Services for neurology and specialist wheelchairs (previously commissioned by Specialist Commissioning).

In 2015/16, the CCG made significant financial investments in all areas of health including elective and non- elective demand management, mental health services and other primary and community services. The CCG continued to work closely with Blackburn with Darwen Borough Council on a number of areas including Integrated Commissioning during the year.

There were a range of financial pressures and risks during 2015/16 including increasing activity in the acute sector, increases in expenditure on prescribing and in growth in continuing healthcare packages.

NHS England delegated the management of the capital funding for GP Information Technology (GPIT) to the CCG for Blackburn with Darwen practices. NHSE approved funding of £148k for GPIT capital schemes in GP IT infrastructure and practice software improvements.

The CCGs financial plan is approved by the Governing Body at the start of the financial year. Budgets and expenditure are monitored formally throughout the year via the integrated business report which is reviewed monthly by the Executive Team and the Governing Body. The CCG also makes financial returns to NHS England as part of the NHS assurance process. The CCG uses the national ledger system which ensures transparency and consistency of financial reporting.

Financial challenges are included in the CCG's corporate risk register which is reviewed by both the CCG Governing Body and CCG's Quality and Performance Committee. The CCG is supported by internal audit and local counter fraud specialists. No specific high risks have been identified.

During 2015/16 the CCG commissioned Midlands and Lancashire Commissioning Support Unit (MLCSU) to provide a range of support services. MLCSU internal audit assurance reports provide significant assurance on a range of financial controls. As there was no transfer of running cost resource for Primary Care Co-Commissioning, the CCG relied on the services of NHS England for the

contracting, quality and finance related to co-commissioning of GP services. These arrangements will continue in 2016/17.

Investments in future years

There will be significant demands on CCG resources over the next few years, the main areas being the health economy financial pressures following the 2016/17 tariff, increasing acute sector activity and new business rules.

In 2016/17, The CCG will have revenue resource available of £246.8m. The CCG is required to maintain an underlying surplus of 1% which can be spent non-recurrently and also deliver a 1% surplus. The CCG is required to hold 1% of the allocation in reserve for the Sustainability and Transformation Plan. This is a new requirement in 2016/17. The CCG will receive an allocation increase of 3.05% resulting in a distance from target of minus 2.46%. Efficiency savings of 2% across all budgets has been assumed and in addition the CCG must deliver a savings/disinvestment programme of £6.9m in order to deliver its 1% surplus. In 2015/16 the CCG will contribute £10.9m into a pooled budget for the Better Care Fund to be spent in partnership with Blackburn with Darwen Borough Council.

In 2016-17, the CCG running cost allocation will remain at £3.5m.

Investments in 2016/17 are consistent with those specified in the CCG 5 year strategic plan but are minimal because of the increasing financial risks and pressures on CCG resources.

Signed:

Dr Chris Clayton

Clinical Chief Officer

Section 2: Accountability Report

2.1 Members of the Governing Body

The following table shows the names and composition of the CCG Governing Body:

Name	Position on the Governing Body	Appointment date
Mr Graham Burgess	Chair and Lay Member for Public Engagement	**1 October 2015**
Dr Chris Clayton	Clinical Chief Officer	**1 July 2012**
Mrs Debbie Nixon	Chief Operating Officer	**1 August 2012**
Mr Roger Parr	Chief Finance Officer	**1 August 2012**
Dr Malcolm Ridgway	Clinical Director Quality and Effectiveness	**1 August 2012**
Dr Nigel Horsfield	Lay Member Secondary Care Doctor	**1 April 2013**
Mrs Anne Asher	Lay Member Nurse Advisor	**1 April 2013**
Mr Paul Hinnigan	Lay Member Governance	**1 August 2012**
Dr Tom Phillips	Executive GP and Clinical Lead	**1 October 2011**
Dr Penny Morris	Executive GP and Clinical Lead	**1 July 2013**
Dr Zaki Patel	Executive GP and Clinical Lead	**1 October 2011**
Dr John Randall	Executive GP and Clinical Lead	**1 May 2015**
Dr Adam Black	Executive GP and Clinical Lead	**1 June 2014**
Dr Pervez Muzaffar	Executive GP and Clinical Lead	**to 31 May 2015**

Blackburn with Darwen CCG has 27 member practices which cover the borough:

- Darwen Health Link Darwen Health Centre
- Darwen Healthcare, Darwen Health Centre
- Dr N Choudry
- Hollins Grove Surgery
- Spring-Fenisco Healthlink
- Stepping Stone Practice
- Bentham Road Health Centre
- Cornerstone Practice, Shadsworth Surgery
- Pringle Street Surgery
- Roman Road Health Centre
- St Georges Surgery
- William Hopwood Street Surgery
- Brookhouse Medical Centre
- Brownhill Surgery
- Little Harwood Health Centre
- Primrose Bank Medical Centre
- Roe Lee Surgery
- Shifa Surgery, Bangor Street
- Umar Medical Centre
- Ewood Medical Centre
- Limefield Surgery
- Oakenhurst Surgery Barbara Castle Way Health Centre
- Redlam Surgery
- The Family Practice Barbara Castle Way Health Centre
- The Montague Practice Barbara Castle Way Health Centre
- The Waterside Practice
- Witton Medical Centre

2.2 CCG's Audit Committee Members

The table below shows the names of the CCG's Audit Committee for the financial year 2015/16:

Name	Position on the Audit Committee
Mr Paul Hinnigan	Chair and Lay Member
Mrs Anne Asher	Lay Member Nurse Advisor
Dr Nigel Horsfield	Lay Member Secondary Care Doctor
Dr Tom Phillips	Executive GP and Clinical Lead

Details of other members of other committees and sub-committees can be found in the Annual Governance Statement within this Annual Report and Accounts.

2.3 Register of Interests

Details of the conflicts of interest policy and register of interests for the Governing Body members can be found on the CCG's website:

http://www.blackburnwithdarwenccg.nhs.uk/about-us/registers-interests/

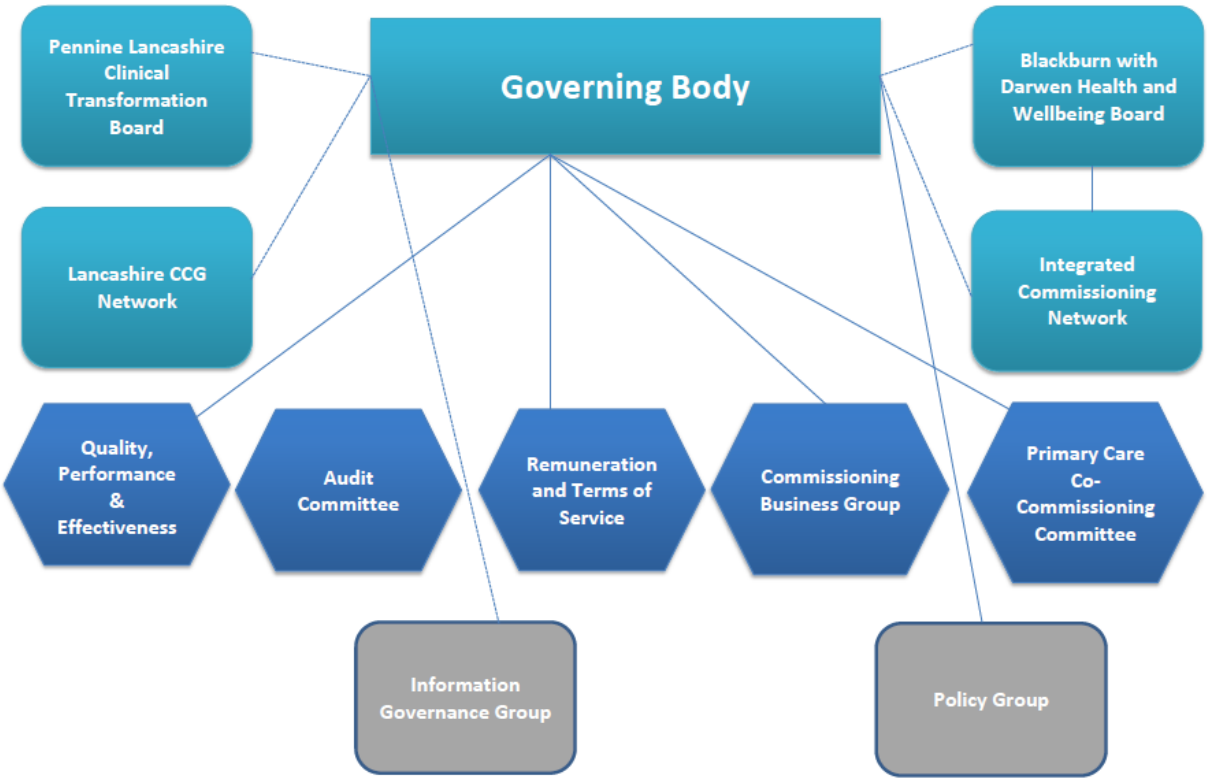
http://www.blackburnwithdarwenccg.nhs.uk/about-us/policies-procedures/

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

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

Governance Structure of the CCG

The diagram below shows the governance structure for Blackburn with Darwen CCG:



2.4 Disclosure of Personal Data Related Incidents

All NHS organisations must include details of incidents involving data loss or confidentiality breaches in their annual report.

The CCG's Annual Governance Statement confirms that for the reporting period 2015/16 there was one personal data related incident which involved a confidentiality breach; measures were implemented to prevent a re-occurrence of the incident. This was not deemed to be a Serious Untoward Incident and did not require reporting to the Information Commissioner's Office.

2.5 Principles for remedy

The CCG Constitution (section 4.4) requires the Organisation to be compliant with "Good Governance Standards for Public Service". This code works in parallel with other codes of practice which for the NHS Complaints procedure is included within the Parliamentary and Health service Ombudsman guide to the "principle of remedy".

The six principles are:

- Getting it right
- Being customer focussed
- Being open and accountable

- Acting fairly and proportionately
- Seeking continuous improvement
- Financial and non-financial remedies

The CCG Constitution embraces all of these principles within the Vision, Values and Aims of the organisation (section 4.1, 4.2, 4.3).

http://www.blackburnwithdarwenccg.nhs.uk/about-us/publications/

The CCG is fully compliant with the current NHS Complaints guidance and the financial framework within the CCG allows for financial remedy if required. This may be instigated by either the CCG or recommended by outside bodies where appropriate.

2.6 Statement of Accounting 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 Clinical Chief Officer to be the Accountable Officer of the Clinical Commissioning Group.

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

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year. In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the Manual for Accounts issued by the Department of Health and in particular to:

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

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

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 judgements required for determining that it is fair, balanced and understandable.

Dr Chris Clayton

Clinical Chief Officer

2.7 ANNUAL GOVERNANCE STATEMENT 2015/16

Governance Statement by the Clinical Chief Officer as the Accountable Officer of NHS Blackburn with Darwen Clinical Commissioning Group

Introduction and Context

The clinical commissioning group 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 2015, the clinical commissioning group was licensed without conditions.

Scope of Responsibility

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

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

Compliance with UK Corporate Governance Code

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

- CCG members and the Governing Body understand and are supportive of their respective roles within decision-making towards improving patient experience and the quality of commissioned services.
- The CCG works collaboratively with key stakeholders to improve health outcomes for patients and the public.
- The CCG is aware of, and understands the relationships required between other CCGs, commissioning organisations and regulators in relation to the local and national health economy.
- The CCG and its Governing Body accepts and acts in accordance with its collective accountability to its membership drawing on the strengths and expertise of individual contributions when necessary.
- The Governing Body is satisfied it has robust and effective processes for decision making as outlined in the CCG's Constitution and that transparency and accountability is in evidence at every level.

The Clinical Commissioning Group Governance Framework

The NHS 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 is complies with such generally accepted principles of good governance as are relevant to it.

The clinical commissioning group's constitution outlines the principles of good governance which must be adhered to at all times in the way in which the group conducts its business. These include the 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.

The key features of the constitution in relation to governance include:

- Standing orders
- Scheme of reservation and delegation
- Prime Financial Policies
- The Nolan Principles
- The Seven Key Principles of the NHS Constitution
- Committee Terms of Reference
- Standard for Members of NHS Board and Clinical Commissioning Groups

The clinical commissioning group's constitution established the following committees/sub-committees with:

- CCG Governing Body
- Audit Committee
- Quality, Performance and Effectiveness Committee
- Remuneration and Terms of Service Committee
- Commissioning Business Group
- Primary Care Commissioning Committee
- Information Governance Steering Group
- Executive Joint Commissioning Group (this group was established an Integrated Commissioning Network which is a joint arrangement with Blackburn with Darwen Borough Council)

The Governing Body has met formally in public on 6 occasions up until 31st March 2016 and has been quorate on each occasion that it has met.

CCG Governing Body

The role of the Governing Body is to:

a. commission safe and effective community and secondary health care services

b. continually work towards the quality improvement of health care

c. work in partnership with other Clinical Commissioning Groups and agencies to secure the overall health and well-being of the population

d. conduct the business in accordance with the constitution of the CCG and the NHS constitution and other NHS statutory guidance.

The Governing Body has 13 members who are able to vote on decisions. They consist of:

- The Clinical Chief Officer
- Clinical Director for Quality and Effectiveness
- 5 elected and 2 appointed GP members (the appointments being the Clinical Chief Officer and the Clinical Director for Quality and Effectiveness
- Chief Operating Officer
- Chief Finance Officer
- The Chair (lay member)
- 1 Lay member for Governance
- 1 Lay member Registered Nurse
- 1 Lay member Secondary Care Doctor

Co-opted members include the Director for Public Health – Blackburn with Darwen Borough Council.

In discharging its obligations the CCG Governing Body is responsible and accountable for delivering financial balance, managing risks and for achieving national and local quality, productivity and service delivery targets.

The CCG Governing Body has delegated responsibility for a range of functions to its committees and working group as set out above. The functions are set out in the approved Terms of Reference of each committee/group and the CCG's Standing Orders and Scheme of Delegation.

Throughout the reporting period there has been a shared commitment between Governing Body members and executive officers to support effective performance and enable good governance within 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 objectives and monitored through on-going performance management. The effective use of information and good communication has also supported the Governing Body alongside a rolling programme of leadership development.

The governance structures within the organisation have also supported the Governing Body through the work of a range of committees, each providing assurance of the business transacted at their meetings.

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

Governing Body Membership attendance 2015/16

The CCG Governing Body meets on a monthly basis (bi-monthly in public) and attendance at all meetings is shown in the table below:

Member	Apr 15	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 16	Feb	Mar
Dr Chris Clayton		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Joe Slater (to 31/8/15	✓	✓	✓	✓	✓	x	x	x	x	x	x	x
Mr Graham Burgess (from 1/10/15)	x	x	x	x	x	x	✓	✓	✓	✓	✓	✓
Dr Malcolm Ridgway	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Mrs Anne Asher	✓	✓	✓		✓	✓	✓	✓			✓	
Dr Nigel Horsfield	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Mr Paul Hinnigan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Penny Morris	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Dr Zaki Patel	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓
Dr Tom Phillips	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Dr Pervez Muzaffar (to 31/5/15)	✓	x	x	x	x	x	x	x	x	x	x	x
Dr Adam Black		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Dr John Randall (from 1/5/15)		✓		✓	✓	✓	✓	✓	✓	✓		✓
Mr Roger Parr	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Debbie Nixon	✓		✓	✓	✓	✓		✓			✓	✓

X – not eligible to attend

Primary Care Commissioning Committee (PCCC)

The PCCC came into effect on 1st April 2015 with full delegated responsibility from NHS England to commission primary medical care services in the borough. A memorandum of understanding sets out those areas that are delegated and this is reflected in the Scheme of Reservation and Delegation.

The PCCC was established to provide a decision making forum for the approval of commissioning intentions where the recommended providers are GP practices.

On behalf of the Governing Body, the committee scrutinises and approves proposals ensuring that where the recommended provider of services is a GP practice, there is evidence that the plans:

- Clearly meet local health needs and have been developed appropriately
- Go beyond the scope of the GP contract
- Have been procured using the appropriate methodology
- Promote improvements in the quality of primary medical care
- Demonstrate the achievement of improved outcomes and value for money
- Cannot be delivered by another provider to the same level of quality, specification and/or price
- Include details for monitoring the quality of service provision
- Include the details of any actual or potential conflict of interest having been appropriately declared and entered in the register which is publicly available
- Maintain confidence and trust between patients and GP's

Membership Attendance 2015/16

The PCCC met in public on a bi-monthly basis on 6 occasions during 2015/16 and attendance at the meetings is shown in the table below:

Primary Care Co-Commissioning Committee attendance 2015/16

Core Membership	May15	July 15	Sept 15	Nov 15	Jan 16	Mar 16
Mr Joe Slater/Mr Graham Burgess - Chair	✓	✓		✓	✓	✓
Dr Malcolm Ridgway	✓	✓		✓	✓	
Mrs Debbie Nixon		✓	✓			
Mr Roger Parr	✓	✓	✓	✓	✓	✓
Mrs Anne Asher	✓		✓	✓	✓	✓
Mr Nigel Horsfield	✓	✓	✓	✓	✓	
Mr Paul Hinnigan	✓	✓	✓	✓	✓	✓

Audit Committee

The audit committee has operated throughout the financial year and has been accountable to the Governing Body for providing an independent and objective view of the group's financial systems, financial information and compliance with laws, regulations and directions governing the clinical commissioning group. The committee is chaired by a lay member, and includes attendance from two other lay members and GP representative.

Amongst the main issues considered by the committee during the year are:

- Governance, risk management and internal control - ensuring the establishment and maintenance of an effective system of governance and risk management across the clinical commissioning group including monitoring and review of the organisation's assurance framework and risk register.

- Internal audit – ensuring the audit function established was effective and met the mandatory NHS Internal Audit Standards to provide appropriate assurance to the Governing Body. Ensuring internal audit reports finalised to date were providing a positive assurance overview

- External audit – reviewing the 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 accounts timetable

- Other assurance functions including Counter Fraud arrangements and review of counter fraud work

Audit Committee membership attendance 2015/16

Member	Apr 15	May 15	Aug 15	Nov 15	Feb 16
Mr Paul Hinnigan-Chair	✓	✓	✓	✓	✓
Dr Tom Phillips - GP	✓	✓	✓	✓	
Mrs Anne Asher	✓	✓	✓		✓
Dr Nigel Horsfield	✓	✓	✓		✓

Quality, Performance and Effectiveness Committee

The Quality, Performance and Effectiveness Committee (QPEC) has operated throughout the reporting period meeting on a monthly basis and providing assurance to the Governing Body on all matters relating to the development and implementation of the group's vision and strategy for continuous quality improvement. This has included all aspects of performance management, service effectiveness, patient safety and experience and assurance of compliance with relevant regulatory standards. During the reporting period, the committee has continued to review its Terms of Reference and membership to provide continuity of clinical input.

The committee provides assurance to the CCG Governing Body that a comprehensive and systematic review of the quality of commissioned services takes place, that risks to service quality are proactively managed (through the use of soft and hard intelligence) and mitigated and suitable investigations are commissioned to achieve desired improvements

The Committee ensures that the risk management objectives outlined in the CCG's Risk Management Strategy and policy are met, and oversees the management of all risks on the Corporate Risk Register on behalf of the CCG Governing Body.

During the reporting period the committee has received updates on the CCG's compliance with the HCAI framework and HCAI rates are reported through the monthly Quality, Performance and Effectiveness Report. The report contains information on CCG performance as well as provider quality performance against contractual obligations. QPEC receives regular updates from the work of the serious incident review panel around the progress of investigations and implementation of resultant action plans. The panel works collaboratively with other CCGs to review incidents, and with a wider range of partners for the most serious incidents such as Mental Health Homicide investigations.

The committee has supported the significant contribution the CCG has made to the combined efforts to improve the quality of services across the health economy including oversight of quality improvement plans particularly within the provision of mental health services, cancer services, stroke services, A&E waiting times and the performance management of serious incidents which has been high on the committee's agenda throughout the year.

Quality, Performance and Effectiveness Committee Membership Attendance 2015/16

Core Membership	May15	Jun15	Jul15	Aug15	Oct15	Nov15	Jan16	Feb16	Mar16
Dr Nigel Horsfield – Secondary Care Doctor	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Malcolm Ridgway	✓	✓	✓	✓		✓	✓	✓	
Dr S Gunn – GP			✓	✓				✓	
Mrs Anne Asher – Registered Nurse	✓	✓	✓	✓	✓		✓		✓
Public Health Representative	✓	✓	✓		✓		✓	✓	
Dr Tom Phillips	✓	✓			✓		✓		✓
Mrs Kim Smith/Mr David Rintoul	✓		✓	✓	✓	✓	✓	✓	✓

Commissioning Business Group

The commissioning business group has operated throughout the financial year considering proposals for investment and disinvestment and ensuring decisions and recommendations are based on appropriate evidence including impact on local health inequalities. The group has made recommendations to the Governing Body ensuring commissioning plans take account of appropriate clinical and public engagement in all aspects of the planning and implementation of the commissioning process

Commissioning Business Group Membership Attendance 2015/16

Member	April 15	May 15	Jun 15	Jul 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Dr Chris Clayton		✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Dr Malcolm Ridgway	✓	✓	✓	✓	✓			✓		✓	✓	✓
Mr Roger Parr	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Mrs Debbie Nixon	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Dr Nigel	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓

Horsfield												
Mr Paul Hinnigan	✓		✓			✓	✓	✓	✓	✓	✓	✓
Dr Penny Morris	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓
Dr Zaki Patel	✓	✓	✓	✓			✓	✓	✓		✓	✓
Dr Tom Phillips	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Dr John Randall	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓
Dr Adam Black	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓

Remuneration and Terms of Service Committee

The remuneration and terms of service committee has operated effectively within its authority to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees including executive officers and GP executive members of the Governing Body.

Remuneration and Terms of Service Committee Membership Attendance 2015/16

Member	Apr 15
Joe Slater – Chair	✓
Paul Hinnigan	✓
Anne Asher	✓
Dr Nigel Horsfield	✓

The Clinical Commissioning Group Risk Management Framework

The CCG has a statutory responsibility and regulatory obligations to ensure that systems of control are in place to minimise the impact of all types of risk which could affect the functioning of the organisation.

The CCG has in place a comprehensive Risk Management Strategy and Policy which outlines the CCG's approach to risk management and recognises that successful risk management should be forward thinking, the responsibility of all and integral to all we do. Effective risk management is essential to the good governance of the organisation as there are inherent risks when commissioning the provision of care for patients, determining service priorities and managing projects.

An internal audit review of the CCG's risk maturity level in February 2016 concluded that staff throughout the organisation were aware of the importance, and the organisation's response to risk/enterprise approach to risk management was developed and communicated.

The Governing Body reviews the CCG's Corporate Objectives on an annual basis and then determines what the principal risks to the achievement of those objectives are. Each risk is assigned to a Governing Body member with responsibility for ensuring it is reviewed and managed appropriately.

These risks are recorded on the Governing Body Assurance Framework (GBAF) using the risk assessment process outlined in the strategy and also supported by the risk appetite exercise undertaken by the Governing Body. This helps the Governing Body define the balance between the cost of mitigating the more severe risks and accepting the less severe risks which are not mitigated.

The GBAF is reviewed on a quarterly basis at the Governing Body meeting and any changes must be approved by the Governing Body. Mersey Internal Audit reviewed the CCG's GBAF in January 2016 and concluded that GBAF was designed and operating to meet the Department of Health requirements, and provided reasonable assurance that there is an effective system of internal control to manage the principal risks to the organisation. The report identified that consideration should be given by the Governing Body in demonstrating greater visibility in the use of the GBAF.

The principal risks to the achievement of the CCG's Corporate Objectives are listed below

Corporate Objective 2015/16	**Principal Risks**
To extend the life of our citizens and their quality of life by adding life to years as well as years to life	There is a risk that ineffective commissioning decisions will prevent the CCG from achieving its corporate objectives, improving health and reducing inequalities
To ensure there will be no gaps, no duplication - with integrated services and partnership working; including better relationships with voluntary, community and faith sector organisations	System-wide capacity issues may emerge that prevent the delivery of the CCG's plans and priorities is a risk that the Commissioning Support Unit is unable to provide timely and appropriate support to the CCG (this closed in June 2015) Conflicting priorities between partners including East Lancashire CCG, the Local Authority and our providers may result in health and social care commissioning responsibilities not being aligned
To engage and encourage patients and the public to participate in everything we do and the importance of self-care and family wellbeing	There is a risk that insufficient engagement with patients and the public on CCG priorities and service developments may lead to decisions that do not fully meet their needs and could result in a challenge the CCG
To improve services and tackle inequality, evidence best practice to inform decisions and root out poor practice	Inability to secure active participation from member practices for delivering the CCG's plans around primary care at scale Responsibility for co-commissioning primary care must be carried out within the CCG's existing financial resources - failure to manage this effectively may impact on the delivery of existing CCG plans and priorities Current GP workforce capacity may impact plans for future primary care delivery (this was updated to Clinical Workforce Capacity to reflect the wider system issues re workforce capacity) Failure to effectively manage conflicts of interests if CCG is successful in expression of interest to co-

	commission primary care services with NHS England
To offer effective service interventions which will provide a better experience for patients with privacy and dignity	There is a risk that providers deliver poor quality care and do not meet quality standards and outcomes

Risk Assessment

Operational risks are identified in a number of ways e.g. when a new service development is planned the risks associated with the project will be scoped out and included in the associated business case documentation. Equality Impact Assessments are also undertaken when making commissioning/de-commissioning decisions, which also support the identification of risks and identifies when it is appropriate to consult with members of the public on those decisions. Public stakeholders are involved in managing risks which impact on them through consultation and engagement activities, and lay member representation on clinical commissioning group committees. In addition the CCG has reviewed and published policies on its website for Complaints Management and Raising Concerns/Whistleblowing.

In addition the CCG commissions a range of support services from the CSU including the Equality and Inclusion team, as well as support in the management of Health and Safety, Security Management and Serious Incident performance management. During the reporting period staff have had access to face to face and on-line training, to help them identify and manage risks associated with their roles/responsibilities.

During the reporting period no major risks to governance, risk management or internal control were identified.

During the year risks have been identified through a variety of sources including:

- Complaints and incidents
- Internal investigations
- Internal/external audit reports
- Team meetings
- Information Governance Toolkit self-assessment and risk issues identified and managed by the Information Governance Steering Group
- Risk Assessments
- Equality Impact Assessments/EDS2 Grading System
- Quality, Performance and Effectiveness Committee
- CCG Governing Body meetings

In accordance with the Risk Management Strategy, when new risks are identified for inclusion on the CCG's risk register they are assessed for their likelihood and severity using a 5 x 5 risk assessment matrix. Delivery and adherence to risk management arrangements is the responsibility of everyone within the organisation and every individual staff member has the right to identify any potential or actual risk for service users, staff and the organisation. This is supported by dedicated resources to support managers and staff to ensure compliance with the organisation's risk management requirements.

In all instances where a risk is not to be tolerated at the current level, an action plan is drawn up to set out the steps to be taken to manage that risk, with a nominated responsible person and a deadline for

completion of each action. Control mechanisms are determined by the tactical risk owner and are selected on their ability to prevent, deter or support the management of the risk.

Once the risk assessment has been completed it is approved by a senior executive officer prior to presentation at the QPEC meeting, which has the delegated authority from the Governing Body to oversee the management of the CCG's risk register. QPEC reviews the full corporate risk register on a monthly basis and makes decisions to approve new risks, close risks or change risk rating as recommended by the tactical risk owner.

The Clinical Commissioning Group Internal Control Framework

A system of internal control is a set of processes and procedures in place in the clinical commissioning group to ensure it delivers 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 allows risks to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness. The systems of internal control within the CCG include the assessment management of risk which are monitored through the clinical commissioning group's Audit Committee and are subject to internal and external audit review.

Control mechanisms are embedded within the system of risk management within the organisation; and there were no instances during the reporting period where the control environment was breached. The control mechanisms include:

- Compliance with legislative and regulatory requirements
- Prime Financial Policies
- Sub committees of the Governing Body
- The Governing Body Assurance Framework
- The Corporate Risk Register
- Internal performance management processes as outlined in the CCG Risk Management Strategy and Policy
- Organisational policies and procedures

The GBAF also plays a key role in ensuring the effectiveness of internal control mechanisms. At the beginning of the financial year the CCG reviews the main risks to the delivery of the strategic and operational plans and these risks are reviewed by the Governing Body on a quarterly basis. Discussions have also taken place during the year across the CCG network in Lancashire regarding the risks jointly faced within the health economy, as well as those shared risks with the Local Authority across integrated service provision within Blackburn with Darwen.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other

organisations and individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring that there are robust information governance systems and processes in place to help protect patients and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training (100% compliance) and have implemented a staff information governance handbook to ensure staff are aware of the their information governance roles and responsibilities. Control measures are in place to ensure risks to data security are managed and controlled. All CCG laptops and USB drives are encrypted and electronic devices have password protection. The CCG has demonstrated compliance with Information Governance requirements by completing the Health and Social Care Information Governance Toolkit. The CCG has achieved the nationally mandated level 2 or above on all standards with an overall score of 91% (satisfactory). There have been no significant control issues involving data losses reported at level 2 or above (i.e. a breach that is deemed sufficiently high profile) to the Information Commissioner or any Serious Untoward Incidents relating to data loss or confidentiality breaches, and there are processes in place for incident reporting and investigation of serious incidents. Information risk assessment and management procedures have been approved by the CCG's policy group with a programme established to ensure an information risk culture is fully embedded throughout the organisation.

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

The CCG operates within a clearly defined Governing Body approved constitution covering financial regulations, formal schemes of delegation and systems of internal control. Fair and open competition between prospective contractors or suppliers for NHS contracts in all cases. The CCG uses national, regional and local NHS contracts where possible and the expertise of NHS Shared Business Services for the procurement of goods and services. The CCG authorises managers and staff to procure goods and services within agreed limits. The CCG has established rules on the standards of business conduct and receipt of gifts and hospitality which all staff must adhere to and all CCG employees declare any potential conflicts of interest. The CCG uses Mersey Internal Audit Agency for its local counter fraud services to identify any fraud related issues; during the reporting period no specific high risks have been identified.

Feedback from delegation chains regarding business, use of resources and responses to risk

For all delegated arrangements, key processes have been applied to ensure that resources are used economically, efficiently and effectively. The governing body receives updates on the work of its committees to ensure they are delivering their key objectives. Delegated arrangements between NHS England and the CCG for the commissioning of primary (medical) care services have been reviewed and inform the quarterly self- certification which provides assurance that the delegated functions have discharged appropriately. The CCG has also reviewed its policy in relation to Managing Conflicts of Interests and published a register of commissioning decisions to ensure transparency. Services provided by the Midlands and Lancashire Commissioning Support Unit are reviewed through monthly meetings with a dedicated service director and issues and risks are raised through the CSU Customer Forum.

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.

Capacity to handle risk

The responsibility for the management of risk across the clinical commissioning group resides with the Governing Body which has provided leadership to the risk management process throughout the reporting period. The Quality, Performance and Effectiveness Committee has received and reviewed risks held on the Corporate Risk Register at each of its monthly meeting on behalf of the Governing Body, reporting issues to the Governing Body when relevant,

The Governing Body undertakes an assessment of its own risk appetite to enable those with responsibility for decision making within the organisation to understand the Governing Body's tolerance to risk, in order to achieve the organisation's strategic objectives. Risk management is built into the strategic planning process and then managed operationally through a robust process of governance around decision making set out in the organisation's scheme of delegation.

All staff members are required to complete annual mandatory training including aspects of risk management that are relevant to every employee. This ensures staff have the capabilities and knowledge of basic risk management principles, including fraud, and foreseeing potential risks. Information is also shared through regular staff communication meetings as well as guidance and support from a dedicated risk manager within the organisation.

Review of Effectiveness

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

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principle objectives have been reviewed.

I have been advised on the implications of the results of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and the Quality, Performance and Effectiveness Committee, and where appropriate, plans are in place to address weaknesses which have been identified to ensure continuous improvement of the system is in place.

During the year there were no Internal Audit reports issued with a conclusion of limited or no assurance.

Head of Internal Audit Opinion

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

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 approach of controls put the achievement of a particular objective at risk.

Data Quality

The Governing Body remains satisfied that the data provided to it has generally been acceptable and overall fit for the purpose of monitoring progress against its strategy and business plan. Following the previously reported improvements around data quality relating to community services provided by LCFT, a more open and transparent relationship has been established with the Trust, and this has contributed to the level of assurance around the Trust's operations. Data quality improvement continues to be addressed as part of the on-going contract management process.

Business Critical Models

Business Critical Models are mainly provided by the Midlands and Lancashire Commissioning Support Unit. They are subject to regular external review, the outputs of which are reported to Clinical Commissioning Groups through Service Auditor reports.

Within the CCG Business Critical Models have all been identified and form part of the Clinical Commissioning Group's Information Asset Register database each with a suitably qualified Information Asset Owner, which is publicly available, subject to data confidentiality issues should they apply.

Data Security

The clinical commissioning group has submitted a satisfactory level of compliance with information governance toolkit assessment (Level 2 on all required elements). For the reporting period 2015/16 there was one personal data related incident which involved a confidentiality breach; measures were implemented to prevent a re-occurrence of the incident. This was not deemed to be a Serious Untoward Incident and did not require reporting to the Information Commissioner's Office.

Discharge of Statutory Functions

Arrangements put in place by the clinical commissioning group and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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 clinical commissioning group'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.

My review concludes that NHS Blackburn with Darwen Clinical Commissioning Group has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and no significant control issues have been identified.

Signed:

Dr Chris Clayton

Clinical Chief Officer

Section 3: Remuneration and Staff Report

3.1 Remuneration Policy

The remuneration levels for the Governing Body members and senior managers of the CCG have been approved by the Remuneration Committee with reference to the Lancashire Clinical Commissioning Group Network guidance, Price Waterhouse Coopers GP remuneration report and the Lancashire benchmarking exercise on senior manager remuneration.

The Remuneration and Terms of Service Committee roles and responsibilities include determining the remuneration and conditions of service of the senior team, reviewing the performance of the executive and other senior roles and determining annual salary pay awards, if appropriate. The Remuneration Committee will consider severance payments of the senior managers, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money' (available on the HM Treasury.gov.uk website).

Senior Managers employed by Blackburn with Darwen CCG do not receive performance related pay.

3.1.1 Remuneration and Terms of Service Committee

The membership of the Remuneration and Terms of Service Committee during 2015/16 was:

Mr Graham Burgess – Chair (from 1 October 2015)
Mr Joe Slater – Chair (to 31 August 2015)
Mr Paul Hinnigan – Lay Member –Governance
Mrs Anne Asher – Lay Member – Nurse Representative
Dr Nigel Horsfield – Lay Member - Secondary Care Doctor

The CCG's Clinical Chief Officer, the Chief Finance Officer and a Human Resources representative also attended Remuneration Committee meetings during 2015/16 to assist in its decision making.

Attendance at the CCG's Remuneration and Terms of Service Committee 2015/16 is shown in the table below:

	Apr 15
Joe Slater – Chair	✓
Paul Hinnigan	✓
Anne Asher	✓
Dr Nigel Horsfield	✓

3.2 Remuneration Report Tables

Senior Managers' Service Contracts

Name	Post	Nominations	Appointment process	Terms of Office	Eligibility for reappointment	Grounds for removal from office	Notice Period
Dr Chris Clayton	Chief Clinical Officer	By GP membership	Panel interview and assessment centre	Permanent	N/A	Termination of contract of employment	6 months
Mrs Debbie Nixon	Chief Operating Officer	By application	Panel interview and assessment centre	Permanent	N/A	Termination of contract of employment	6 months
Mr Roger Parr	Chief Finance Officer	By application Must be a qualified accountant	Panel interview and assessment centre	Permanent	N/A	Termination of contract of employment	6 months
Mr Graham Burgess	Chair	By application	Panel interview and assessment centre	3 years	By application and interview	Vote of no confidence by the Governing Body	1 month
Mr P Hinnigan, Mrs A Asher, Dr N Horsfield	Lay members	By application and appointment	Application and panel interview	3 years	By application and interview	Termination of contract	1 month
Dr Malcolm Ridgway	Clinical Director for Quality and Effectiveness	By application	Panel interview and assessment centre	Permanent	N/A	Termination of contract of employment	3 months
Dr P Morris, Dr T Phillips, Dr J Randall, Dr Z Patel, Dr A Black	Governing Body GPs	By application	Election by membership	3 years	Nomination and election	Recommendation to Senate by CCO or through motion raised by CCG members and agreed by 75% majority of CCG members	1 month

Salaries and Wages 2015/16

Name & Title	Salary & Fees (bands of £5,000)	Taxable Benefits (Rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-tern Performance Related Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£00	£00	£000	£000	£000
Mr Graham Burgess-Chair (from 1/10/15)	15-20	20	0	0	0	15-20
Mr Joe Slater – Chair (to 31/8/15)	10-15	0	0	0	0	10-15
Dr Chris Clayton – Clinical Chief Officer	135-140	0	0	0	0	135-140
Dr Malcolm Ridgway – Clinical Director of Quality and Effectiveness	100-105	0	0	0	0	100-105
Mr Paul Hinnigan – Lay Member–Governance	15-20	0	0	0	0	15-20
Mrs Anne Asher – Lay Member – Nurse Representative	10-15	0	0	0	0	10-15
Mr Nigel Horsfield – Lay Member – Secondary Care Doctor	10-15	0	0	0	0	10-15
Mr Roger Parr – Chief Finance Officer	95-100	0	0	0	25-27.5	125-130
Mrs Debbie Nixon – Chief Operating Officer	95-100	0	0	0	2.5-5	100-105
Dr Pervez Muzaffar- Governing Body GP (to 31/5/15)	5-10	0	0	0	0-2.5	5-10
Dr Tom Phillips- Governing Body GP	30-35	0	0	0	0	30-35
Dr Zaki Patel-Governing Body GP	30-35	0	0	0	0	30-35
Dr Penny Morris – Governing Body GP	30-35	0	0	0	2.5-5.0	35-40
Dr Adam Black-Governing Body GP	30-35	0	0	0	45.0-47.5	75-80
Dr John Randall –Governing Body GP (from 1/5/15)	30-35	0	0	0	5.0-7.5	35-40

Benefits in Kind include provision for taxable travel expenses

Salaries and Wages 2014-15

Name & Title	Salary & Fees (bands of £5,000)	Taxable Benefits (Rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long-tern Performance Related Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
	£000	£00	£00	£000	£000	£000
Mr Joe Slater – Chair	30-35	0	0	0	0	30-35
Dr Chris Clayton – Chief Clinical Officer	130-135	0	0	0	47.5-50	180-185
Dr Malcolm Ridgway – Clinical Director of Quality and Effectiveness	85-90	0	0	0	0	85-90
Mr Paul Hinnigan – Lay Member–Governance	10-15	0	0	0	0	10-15
Mrs Anne Asher – Lay Member – Nurse Representative	10-15	0	0	0	0	10-15
Mr Nigel Horsfield – Lay Member – Secondary Care Doctor	10-15	0	0	0	0	10-15
Mr Roger Parr – Chief Finance Officer	95-100	0	0	0	27.5-30	125-130
Mrs Debbie Nixon – Chief Operating Officer	95-100	0	0	0	0	100-105
Dr Pervez Muzaffar- Governing Body GP	30-35	0	0	0	20-22.5	55-60
Dr Tom Phillips- Governing Body GP	30-35	0	0	0	62.5-65	95-100
Dr Zaki Patel-Governing Body GP	30-35	0	0	0	0	30-35
Dr Penny Morris – Governing Body GP	30-35	0	0	0	0-2.5	30-35
Dr Adam Black-Governing Body GP (from 1st June 2014)	25-30	0	0	0	2.5-5.0	30-35

Benefits in Kind include provision for taxable travel expenses

Pension Benefits 2015-16

Name	Real increase in pension at pension age (bands of £2500) £000	Real increase in pension lump sum at pension age (bands of £2500) £000	Total accrued pension at pension age at 31 March 2016 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Cash Equivalent Transfer value at 31 March 2016 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Dr Chris Clayton	0-2.5	0-2.5	10-15	30-35	149	159	9	0
Dr Pervez Muzaffar	0-2.5	0-2.5	5-10	20-25	152	154	0	0
Dr Tom Phillips	0-2.5	0-2.5	10-15	35-40	237	239	3	0
Dr Penny Morris	0-2.5	0-2.5	0-5	0-5	10	18	8	0
Dr Adam Black	0-2.5	0	0-5	0	4	27	23	0
Dr John Randall	0-2.5	0-2.5	5-10	25-30	194	213	18	0
Mrs Debbie Nixon	0-2.5	0-2.5	35-40	115-120	736	759	23	0
Mr Roger Parr	0-2.5	0-2.5	30-35	85-90	450	471	21	0

Note:

The GP employments do not include any practitioner employments

Pension Benefits 2014-15

Name	Real increase in pension at age 60 (bands of £2500) £000	Real increase in pension lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Cash Equivalent Transfer value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to stakeholder pension £00
Dr Chris Clayton	2.5-5	7.5-10	10-15	30-35	104	148	42	0
Dr Pervez Muzaffar	0-2.5	2.5-5	5-10	20-25	121	150	26	0
Dr Tom Phillips	2.5-5	7.5-10	10-15	35-40	168	234	61	0
Dr Penny Morris	0-2.5	0-2.5	0-5	0-5	5	10	5	0
Dr Adam Black	0-2.5	0	0-5	0	0	4	4	0
Mrs Debbie Nixon	0-2.5	0-2.5	35-40	115-120	684	727	25	0
Mr Roger Parr	0-2.5	5-7.5	25-30	85-90	395	445	39	0

Note:

The GP employments do not include any practitioner employments

There are no figures for 2014 for Dr Adam Black as he does not have any officer service prior to 1st June 2014

Pension Entitlements

- **Cash Equivalent Transfer Values**

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated 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 period.

Change in SCAPE discount rate for pensions

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% 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 Pensions scheme are based on the previous discounted rate and have not been recalculated.

3.3 Compensation for Early Retirement or Loss of Office

During 2015-16, a payment in the range of £5k-£10k was made to Dr P Muzaffar as compensation for loss of office. (2014-15 £0-£5k).

There is no provision in the 2015-16 accounts for compensation for early termination.

3.4 Payments to Past Senior Managers

There have been no payments made to past directors of Blackburn with Darwen Clinical Commissioning Group during 2015-16.

3.5 Pay Multiples

The CCG is required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director on the Governing Body in Blackburn with Darwen Clinical Commissioning Group in the financial year 2015 was £135k-£140k (2014-15 £130k-£135k). This was 4.2 times (2014-15 3.9 times) the median remuneration of the workforce which was £33,371 (2014-15 £33,371). Remuneration ranged from £6k-£139k (2014-15 £5k - £131k).

In 2015-16, no employee received remuneration in excess of the highest paid director.

Total remuneration includes salary, non-consolidated performance-related pay and benefits in equivalent transfer value of pensions.

The calculation is based on the full-time equivalent of the clinical commissioning group at the reporting period end date on an annualised basis.

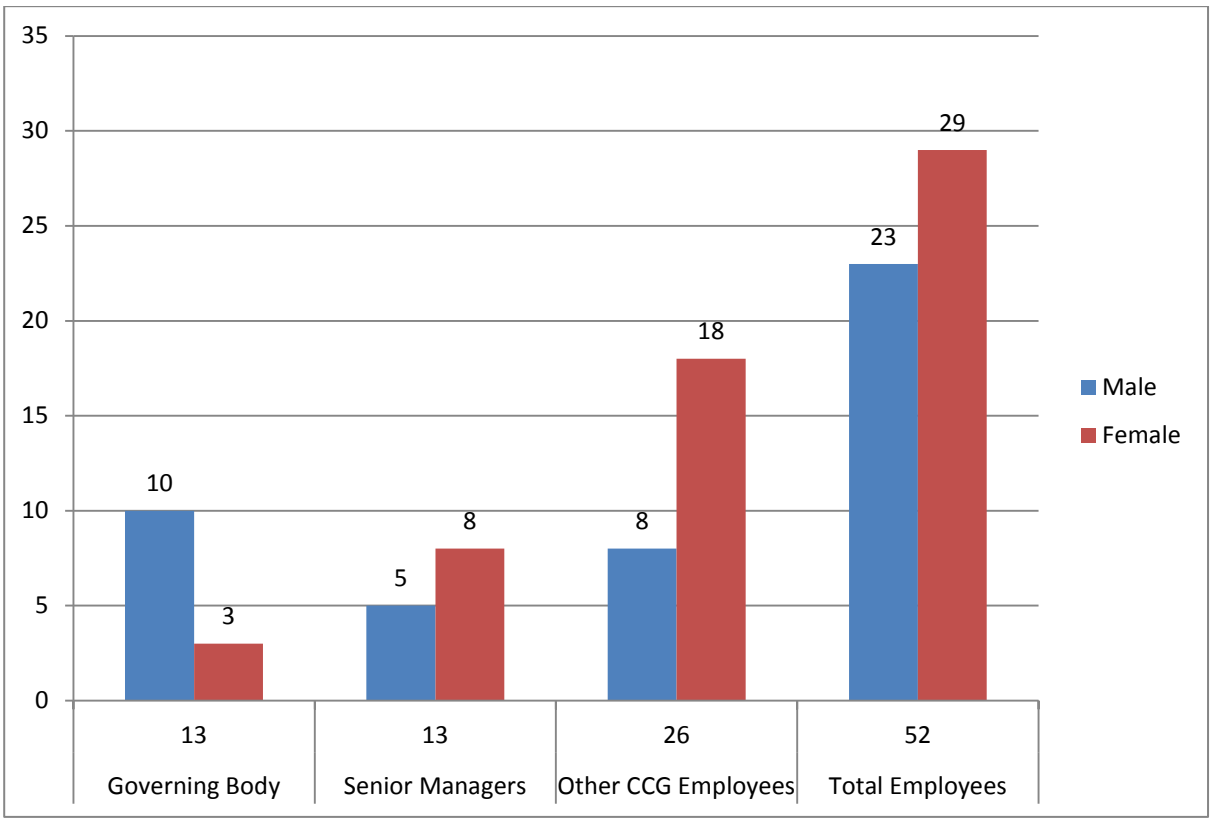
3.6 Remuneration of Very Senior Managers

The CCG is required to disclose where one or more senior managers of the CCG are paid more than £142,500 per annum – equivalent to the Prime Minister's Salary.

Blackburn with Darwen CCG has two senior managers who are paid more than £142,500 per annum (on a pro-rata basis). The salaries for the two roles were agreed by the CCG's Remuneration Committee, were benchmarked locally against comparable NHS roles and were based on an independent review for the Lancashire Clinical Commissioning Group Network 'Guidance on Remuneration' undertaken by PriceWaterhouse Coopers.

3.7 Staff Number by Band and staff composition

The table below shows the analysis of staff number and composition by gender based on headcount of staff employed at 31st March 2016.



The average number of staff employed during 2015-16 is 31.6wte.

3.8 Sickness Absence Data

Total Days Lost	167
Total Staff Years	38
Average working days lost	4.4

The CCG commissions occupational health services via Midlands and Lancashire Commissioning Support Unit. We have supported staff to take advantage of the service as and when necessary.

3.9 Staff Policies

The staff policies in place during 2015-16 can be seen on the Blackburn with Darwen Clinical Commissioning Group website. **http://www.blackburnwithdarwenccg.nhs.uk/about-us/policies-procedures/**

3.10 Expenditure on consultants

There is no expenditure on consultancy reported in Blackburn with Darwen CCG accounts for 2015-16.

3.11 Exit Packages

There were no exit packages agreed during 2015-16 by Blackburn with Darwen Clinical Commissioning Group.

3.12 Off payroll engagements

Following the Review of Tax Arrangements of Public Sector Appointees published by the Chief Secretary to the Treasury on 23 May 2012, the clinical Commissioning Group is required to publish information on their highly paid and /or off payroll engagements

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 2015	0
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	0
For between 2 and 3 years at the time of reporting	0
For between 3 and 4 years at the time of reporting	0
For 4 or more years at the time of reporting	0

All payroll engagements have been subject to a risk based assessment that the individual is paying the right amount of tax and assurance has been sought.

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 between 1 April 2014 and 31 March 2015	0
Number of new engagements which include contractual clauses giving Blackburn with Darwen CCG the right to request assurance in relation to income tax and National Insurance obligations	0
Number of whom assurance has been requested	0
Of which:	
Assurance has been received	0
Assurance has not been received	0
Engagement terminated as a result of assurance not being received, or ended before assurance received	0

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed “Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility” during the financial year (this figure includes both off-payroll and on-payroll engagements)	0

ANNUAL ACCOUNTS 2015-16

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	2,390	2,180
Operating Expenses	5	238,623	205,834
Other operating revenue	2	(690)	(453)
Net operating expenditure before interest		**240,323**	**207,561**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	1,498	1,607
Operating Expenses	5	1,975	2,009
Other operating revenue	2	0	(1)
Net administration costs before interest		**3,473**	**3,615**
Programme Income and Expenditure			
Employee benefits	4.1.1	892	573
Operating Expenses	5	236,648	203,825
Other operating revenue	2	(690)	(452)
Net programme expenditure before interest		**236,850**	**203,946**

The notes on pages 67 to 86 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	10	1,376	1,020
Cash and cash equivalents	11	0	0
Total current assets		**1,376**	1,020
Total assets		**1,376**	1,020
Current liabilities			
Trade and other payables	12	(10,342)	(9,637)
Provisions	13	(1)	0
Total current liabilities		**(10,343)**	(9,637)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(8,967)**	(8,617)
Non-current liabilities			
Provisions	13	(28)	(42)
Total non-current liabilities		**(28)**	(42)
Assets less Liabilities		**(8,995)**	(8,659)
Financed by Taxpayers' Equity			
General fund		(8,995)	(8,659)
Total taxpayers' equity:		**(8,995)**	(8,659)

The notes on pages 67 to 86 form part of this statement

The financial statements on pages 63 to 66 were approved by the Audit Committee on 20 May 2016 and signed on its behalf by:

Signature:

Dr Christopher Clayton
Clinical Chief Officer

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

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(8,659)	0	0	**(8,659)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(8,659)**	**0**	**0**	**(8,659)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(240,323)			(240,323)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Yea	**(248,982)**	**0**	**0**	**(248,982)**
Net funding	239,987	0	0	239,987
Balance at 31 March 2016	**(8,995)**	**0**	**0**	**(8,995)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(8,866)**	**0**	**0**	**(8,866)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Commissioning Board balance at 1 April 2014	**(8,866)**	**0**	**0**	**(8,866)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs for the financial year	(207,561)			(207,561)
Net funding	207,768	0	0	207,768
Balance at 31 March 2015	**(8,659)**	**0**	**0**	**(8,659)**

The notes on pages 67 to 86 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		(240,323)	(207,561)
(Increase)/decrease in trade & other receivables	10	(356)	(272)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	12	705	23
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	13	0	0
Increase/(decrease) in provisions	13	(13)	42
Net Cash Inflow (Outflow) from Operating Activities		**(239,987)**	(207,768)
Net Cash Inflow (Outflow) before Financing		**(239,987)**	(207,768)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		239,987	207,768
Net Cash Inflow (Outflow) from Financing Activities		**239,987**	207,768
Net Increase (Decrease) in Cash & Cash Equivalents	20	**0**	0
Cash & Cash Equivalents at the Beginning of the Financial Year		**0**	0
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**0**	0

The notes on pages 67 to 86 form part of this statement

1 Accounting Policies

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

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 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.

recognises:

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

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

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

1.6 **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.

1.6.1 ***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 portfolio of leases has been reviewed and a management judgement has been made that the leases should be classified as operating leases.

1.6.2 **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 have been applied. This is because the outturn information is not available at the time of preparation of the financial statements. Examples of significant accruals involving estimation are prescribing costs and expenditure dependent on secondary, tertiary and independent sector activity information.

1.7 **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.

1.8 **Employee Benefits**

1.8.1 **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.

1.8.2 **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.

1.9 **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.

1.10 **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.

1.10.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.10.2 **The Clinical Commissioning Group as Lessor**

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

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

1.11 **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.

1.12 **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%)

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.

1.13 **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.

1.14 **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.

1.15 **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.

1.16 **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.

1.17 **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.

1.18 **Financial Assets**

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.

1.18.1 **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.

1.18.2 **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.

1.18.3 **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.

1.18.4 **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.

1.19 **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.

1.19.1 **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.

1.19.2 **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.

1.19.3 **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.

1.20 **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.

1.21 **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.

1.22 **Third Party Assets**

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

1.23 **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).

1.24 **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
Prescription fees and charges	0	0	0	6
Education, training and research	53	0	53	21
Non-patient care services to other bodies	390	0	390	180
Other revenue	246	0	246	246
Total other operating revenue	**689**	**0**	**689**	**453**

Prescribing	180
GP Cancer Lead	32
Mental Health Winter Resilience	20
Cancer Improvement Scheme	14
	246

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	689	0	689	453
From sale of goods	0	0	0	0
Total	**689**	**0**	**689**	**453**

Note
Non-patient care services to other bodies includes income from the Better Care Fund for the first time in 2015-16.

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	1,978	1,904	74	1,217	1,217	0	761	687	74
Social security costs	182	182	0	121	121	0	61	61	0
Employer Contributions to NHS Pension scheme	230	230	0	160	160	0	70	70	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,390**	**2,316**	**74**	**1,498**	**1,498**	**0**	**892**	**818**	**74**
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	**2,390**	**2,316**	**74**	**1,498**	**1,498**	**0**	**892**	**818**	**74**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,390**	**2,316**	**74**	**1,498**	**1,498**	**0**	**892**	**818**	**74**

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	1,805	1,727	78	1,313	1,308	5	492	419	73
Social security costs	171	171	0	136	136	0	35	35	0
Employer Contributions to NHS Pension scheme	204	204	0	158	158	0	46	46	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	0	0	0	0	0	0	0	0	0
Gross employee benefits expenditure	**2,180**	**2,102**	**78**	**1,607**	**1,602**	**5**	**573**	**500**	**73**
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	**2,180**	**2,102**	**78**	**1,607**	**1,602**	**5**	**573**	**500**	**73**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**2,180**	**2,102**	**78**	**1,607**	**1,602**	**5**	**573**	**500**	**73**

4.2 Average number of people employed

	2015-16			2014-15
	Total Number	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**37**	**36**	**1**	37
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	**2014-15 Number**
Total Days Lost	167	92
Total Staff Years	38	35
Average working Days Lost	**4.4**	**2.6**

There were no persons retired early on ill health grounds during 2015-16 (2014-15 nil).

4.4 Exit packages agreed in the financial year

There were no exit packages agreed during 2015-16 by Blackburn with Darwen CCG (2014-15 nil).

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

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 £230,036 were payable to the NHS Pensions Scheme (2014-15: £204,901) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9th 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	1,707	815	892	1,472
Executive governing body members	683	683	0	708
Total gross employee benefits	**2,390**	**1,498**	**892**	**2,180**
Other costs				
Services from other CCGs and NHS England	2,718	1,347	1,371	2,719
Services from foundation trusts	42,962	24	42,938	40,432
Services from other NHS trusts	108,644	40	108,604	108,642
Services from other NHS bodies	0	0	0	0
Purchase of healthcare from non-NHS bodies	30,122	0	30,122	23,282
Chair and Non Executive Members	85	85	0	86
Supplies and services – clinical	192	0	192	140
Supplies and services – general	525	129	396	(272)
Consultancy services	0	0	0	42
Establishment	512	108	404	596
Transport	10	6	4	9
Premises	2,331	162	2,169	2,408
Audit fees	54	54	0	67
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	27,995	0	27,995	26,711
General ophthalmic services	8	0	8	13
GPMS/APMS and PCTMS	21,287	0	21,287	495
Other professional fees excl. audit	42	5	37	75
Grants to other public bodies	66	0	66	0
Education and training	62	15	47	53
Provisions	(13)	0	(13)	42
Funding to group bodies		0	0	0
CHC Risk Pool contributions	1,020	0	1,020	294
Total other costs	**238,622**	**1,975**	**236,647**	**205,834**
Total operating expenses	**241,012**	**3,473**	**237,539**	**208,014**

Purchase of healthcare from non-NHS bodies - includes expenditure for the Better Care Fund for the first time in 2015-16.
GPMS/APMS and PCTMS - includes expenditure related to Primary Care Co-Commissioning for the first time in 2015-16.

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	6483	41030	5,942	28,385
Total Non-NHS Trade Invoices paid within target	6407	40728	5,886	27,962
Percentage of Non-NHS Trade invoices paid within target	**98.83%**	**99.26%**	**99.06%**	**98.51%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2174	155385	1899	152506
Total NHS Trade Invoices Paid within target	2154	155124	1876	152466
Percentage of NHS Trade Invoices paid within target	**99.08%**	**99.83%**	**98.79%**	**99.97%**

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

7 Income Generation Activities

Blackburn with Darwen Clinical Commissioning Group received £15,605 in respect of income generation activities in respect of medicines management training provided.

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

No functions were transferred by Blackburn with Darwen Clinical Commissioning Group during 2015-16 therefore no gain or loss was recognised during the financial year.

9. Operating Leases

9.1 As lessee

9.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	**Buildings £000**	**Other £000**	**Total £000**	**Land £000**	**Buildings £000**	**Other £000**	**Total £000**
Payments recognised as an expense								
Minimum lease payments	0	2,298	0	**2,298**	0	2,394	0	**2,394**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**2,298**	**0**	**2,298**	**0**	**2,394**	**0**	**2,394**

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 payments for the arrangements only

9.1.2 Future minimum lease payments

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

9.2 As lessor

Blackburn with Darwen Clinical Commissioning Group was party to no leases during 2015-16 as a lessor.

10 Trade and other receivables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	266	0	148	0
NHS prepayments	118	0	544	0
NHS accrued income	0	0	0	0
Non-NHS receivables: Revenue	890	0	143	0
Non-NHS prepayments	45	0	175	0
Non-NHS accrued income	52	0	0	0
Provision for the impairment of receivables	0	0	0	0
VAT	5	0	10	0
Total Trade & other receivables	**1,376**	**0**	**1,020**	**0**
Total current and non current	**1,376**		**1,020**	
Included above:				
Prepaid pensions contributions	0		0	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to Clinical Commissioning Groups to commission services, no credit scoring of them is considred necessary.

10.1 Receivables past their due date but not impaired	2015-16 £000	2014-15 £000
By up to three months	158	0
By three to six months	17	7
By more than six months	12	0
Total	**187**	**7**

£0 the amount above has subsequently been recovered post the statement of financial position date.

Blackburn with Darwen CCG did not hold any collateral against receivables outstanding at 31 March 2016.

10.2 Provision for impairment of receivables	2015-16 £000	2014-15 £000
Balance at 01-April-2015	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31-March-2016	**0**	**0**

Blackburn with Darwen 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 invoices were written off during 2015-16. There are two non NHS Debtor outstanding totalling £18,492 which are over 60 days old.

	2015-16 £000	2014-15 £000
Receivables are provided against at the following rates:		
NHS debt	0%	0%

11 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	0	0
Net change in year	0	0
Balance at 31-March-2016	**0**	**0**
Made up of:		
Cash with the Government Banking Service	0	0
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**0**	**0**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**0**	**0**
Patients' money held by the clinical commissioning group, not included above	0	0

12 Trade and other payables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS payables: revenue	2,830	0	2,337	0
NHS accruals	670	0	682	0
Non-NHS payables: revenue	989	0	1,144	0
Non-NHS accruals	5,703	0	5,241	0
Social security costs	26	0	26	0
VAT	0	0	0	0
Tax	32	0	32	0
Payments received on account	0	0	0	0
Other payables	92	0	175	0
Total Trade & Other Payables	**10,342**	**0**	**9,637**	**0**
Total current and non-current	**10,342**		**9,637**	

Included above are liabilities of £0 [nil], for 0 [nil] people, due in future years under arrangements to buy out the liability for early retirement over 5 years (31 March 2015: £0 [nil] for 0 [nil] people.

Other payables include £35k outstanding pension contributions at 31 March 2016. [£32k at 31 March 2015]

13 Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	1	0	0	0
Continuing care	0	28	0	42
Other	0	0	0	0
Total	**1**	**28**	**0**	**42**
Total current and non-current	**29**		**42**	

	Pensions Relating to Former Directors £000s	**Pensions Relating to Other Staff £000s**	**Restructuring £000s**	**Redundancy £000s**	**Agenda for Change £000s**	**Equal Pay £000s**	**Legal Claims £000s**	**Continuing Care £000s**	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**42**	**0**	**42**
Arising during the year	0	0	0	0	0	0	1	0	0	1
Utilised during the year	0	0	0	0	0	0	0	0	0	0
Reversed unused	0	0	0	0	0	0	0	(14)	0	(14)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**28**	**0**	**29**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	1	0	0	1
Between one and five years	0	0	0	0	0	0	0	28	0	28
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31-March-2016	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**28**	**0**	**29**

Under Accounts Directions issued by NHS England on 24 February 2015, NHS England is responsible for the accounting for liabilities relating to NHS Continuing Healthcare claims relating to previously unassessed periods of care, before the establishment of Clinical Commissioning Groups. The legal liability to discharge these claims remains with the CCG.

Legal claims are calculated from the number of claims currently lodged with the NHS Litigation Authority and the probabilities provided by them. Blackburn with Darwen CCG currently has one claim lodged with NHS Litigation Authority.

14 Contingencies

	2015-16 £000	2014-15 £000
Contingent liabilities		
Equal Pay	0	0
Employment Tribunal	0	0
NHSLA employee liability claim	0	0
Redundancy	0	0
NHS Litigation Authority Legal Claims	2	0
Amounts recoverable against contingent liabilities	0	0
Net value of contingent liabilities	**2**	**0**
Contingent assets		
Amounts payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

15 Financial instruments

15.1 Financial risk management

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

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

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

15.1.1 Currency risk

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

15.1.2 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.

15.1.3 Credit risk

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

15.1.3 Liquidity risk

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

15 Financial instruments cont'd

15.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	266	0	266
· Non-NHS	0	942	0	942
Cash at bank and in hand	0	0	0	0
Other financial assets	0	0	0	0
Total at 31-March-2016	**0**	**1,208**	**0**	**1,208**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	148	0	148
· Non-NHS	0	143	0	143
Cash at bank and in hand	0	0	0	0
Other financial assets	0	0	0	0
Total at 31-March 2015	**0**	**291**	**0**	**291**

15.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,500	3,500
· Non-NHS	0	6,784	6,784
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March-2016	**0**	**10,284**	**10,284**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,020	3,020
· Non-NHS	0	6,560	6,560
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31-March 2015	**0**	**9,580**	**9,580**

16 Operating segments

The Clinical Commissioning Group considers that they have only one operating segment: commissioning of healthcare services.

17 Pooled budgets

The NHS Clinical Commissioning Group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2015-16	2014-15
	£000	£000
Income	5,869	0
Expenditure	10,586	0

The pooled budget records the income and expenditure for the Better Care Fund as managed under a section 75 agreement between Blackburn with Darwen Clinical Commissioning Group and Blackburn with Darwen Borough Council.

18 Related Party Transactions

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group

The general medical practitioners listed below are members of the Clinical Commissioning Group Governing Body and the payments and receipts shown below relate to the general practice in relation to their clinical work as general medical practitioners

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Brookhouse Medical Centre (Dr Z Patel)	644	0	45	0
Cornerstone CIC (Dr A Black)	1,085	0	130	0
Darwen Healthcare (Dr C Clayton & Dr P Morris)	1,500	0	95	0
Darwen Healthlink (Dr P Muzaffar)	1,432	0	38	0
Dr A Murdoch and Partners (Dr A Black)	2,088	0	126	0
Dr TL Phillips	528	0	44	0
Oakenhurst Medical Practice (Dr J Randall)	1,330	0	77	0
Witton Medical Centre (Dr M Ridgway)	1,082	0	85	0

The Department of Health is regarded as a related party. During the year Blackburn with Darwen Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department, for example:

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
East Lancashire Hospital NHS Trust	100,085	3	1,020	1
Lancashire Care NHS Foundation Trust	31,442	2	764	110
North West Ambulance NHS Trust	7,465	0	3	0
Lancashire Teaching NHS Foundation Trust	5,447	0	0	159
NHS Midlands and Lancashire CSU	2,582	10	48	0
NHS Property Services	307	0	0	30

In addition, Blackburn with Darwen Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Blackburn with Darwen Borough Council and Community Health Partnerships Ltd:

Blackburn with Darwen Borough Council	11,661	6,123	48	798
Community Health Partnerships Ltd	2,006	0	0	0

Certain members of the Governing Body (or parties related to them) also have connection with organisations which have transactions with the Clinical Commissioning Group:

NHS East Lancashire CCG	324	582	61	50
East Lancashire Medical Services	2,109	0	189	0
East Lancashire Hospice	1,051	0	66	0

Related Party Transactions 2014-15

During the year none of the Department of Health Ministers, Clinical Commissioning Group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the Clinical Commissioning Group.

The general medical practitioners listed below are members of the Clinical Commissioning Group Governing Body and the payments and receipts shown below relate to the general practice in relation to their clinical work as general medical practitioners

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
Witton Medical Centre (Dr M Ridgway)	106	0	0	0
Dr TL Phillips	37	0	0	0
Dr E Ahmed & Partners (Dr P Muzaffar)	50	0	0	0
Brookhouse Medical Centre (Dr Z Patel)	65	0	0	0
Darwen Healthcare (Dr C Clayton & Dr P Morris)	241	0	0	0
Cornerstone CIC (Dr A Black)	52	0	0	0
Dr A Murdoch and Partners (Dr A Black)	46	0	0	0

The Department of Health is regarded as a related party. During the year Blackburn with Darwen Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£000	£000	£000	£000
East Lancashire Hospital NHS Trust	99,364	(11)	2,021	(3)
Lancashire Care NHS Foundation Trust	30,928	(29)	285	(536)
North West Ambulance NHS Trust	7,719	0	0	(1)
Lancashire Teaching NHS Foundation Trust	4,789	0	88	0
NHS Midlands and Lancashire CSU	2,506	(33)	2	(14)
NHS Property Services	412	0	0	0

In addition, Blackburn with Darwen Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Blackburn with Darwen Borough Council and Community Health Partnerships:

Blackburn with Darwen Borough Council	1,240	(592)	608	(136)
Community Health Partnerships Ltd	1,982	0	0	0

Certain members of the Governing Body (or parties related to them) also have connections with organisations which also have transactions with the Clinical Commissioning Group

NHS East Lancashire CCG	265	(371)	22	(27)
East Lancashire Medical Services	2,296	0	0	0
East Lancashire Hospice	1,088	0	0	0
NHS England	0	(283)	0	(44)

19 Events after the end of the reporting period

There are no post balance sheet events which have a material effect on the financial statements of the Clinical Commissioning Group

20 Losses and special payments

20.1 Losses
The Clinical Commissioning Group had no losses cases during 2015-16 (nil in 2014-15)

20.2 Special payments
The Clinical Commissioning Group had no special payments during 2015-16 (nil in 2014-15)

21 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).

NHS Clinical Commissioning Group performance against those duties was as follows:

	Achieved	**2015-16 Target**	**2015-16 Performance**	2014-15 Target	2014-15 Performance
Expenditure not to exceed income	Yes	242,602	241,013	210,325	208,014
Capital resource use does not exceed the amount specified in Directions	N/A	0	0	0	0
Revenue resource use does not exceed the amount specified in Directions	Yes	241,912	240,323	209,872	207,561
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	N/A	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	Yes	20,199	20,199	0	0
Revenue administration resource use does not exceed the amount specified in Directions	Yes	3,736	3,473	4,270	3,616

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BLACKBURN WITH DARWEN CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Blackburn with Darwen Clinical Commissioning Group for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). 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. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

We have also audited the information in the Remuneration and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers in section 3.2;
- the table of pension benefits of senior managers and related narrative notes in section 3.2;
- disclosure of payments for loss of office in section 3.3;
- the analysis of staff numbers in section 3.7; and
- the pay multiples disclosure in section 3.5.

This report is made solely to the members of the Governing Body of NHS Blackburn with Darwen Clinical Commissioning Group, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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 CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring 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 as required by the Act (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 Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

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 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 criteria, 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 these criteria 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, and to report by exception where we are not satisfied.

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 NHS Blackburn with Darwen Clinical Commissioning Group as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; 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 comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Act 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 Act; or
- we make a written recommendation to the CCG under section 24 of the Act; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Blackburn with Darwen Clinical Commissioning Group in accordance with the requirements of the Act and the Code of Audit Practice

Karen Murray
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton UK LLP
4 Hardman Square
Spinningfields
Manchester
M3 3EB

20 May 2016