NHS
Bath and North East Somerset
Clinical Commissioning Group

Annual Report and Accounts 2015/16

Healthier. Stronger. Together.

Contents

NHS Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) is a membership organisation, made up of local GPs and practice staff from all 27 surgeries within B&NES. In 2015/16 our budget was £216,700,000. Our geographical boundary matches that of B&NES Council. The number of patients registered with practices is higher than the resident population, at 199,660 patients (March 2014).

The accounts in this report have been prepared in accordance with the Department of Health Manual for Accounts 2015/16 and associated guidance.

Section 1: Performance Report

Chief Officer and Chair's Foreword

Welcome to the 2015/16 Annual Report and Accounts for NHS Bath and North East Somerset Clinical Commissioning Group (BaNES CCG).

This is the CCG's third year of operation and it has been challenging on a number of fronts. The NHS is under unprecedented financial strain, and the demand and pressure on services continues to increase. The CCG has seen a significant increase in demand for emergency and elective care, which has put pressure on our budget. Despite performing well against most NHS Constitution targets and achieving good levels of satisfaction for patient experience, there are two key areas, namely four hour waiting time in A&E and 18-week 'referral to treatment times' for patients, where performance is not in line with the expected standards. Improving performance in these areas is therefore a key focus for the CCG.

The Five Year Forward View (2014) set out how the NHS needs to adapt and innovate in order to deliver sustainable, high quality services for future generations. In spite of the challenges we have faced this year, we are pleased to share within the pages of this report, some project highlights that show how what we are doing to ensure our health and care services are on a sustainable footing.

One key project has been ***your care, your way***, our review of community services in partnership with Bath and North East Somerset Council. Our ambitious plans for delivering health and care community services were developed following ten months of engagement with local people and providers.

One of the strongest features of ***your care, your way*** (which you can read more about on pages 9 and 28) is the focus on health and care services working closer together in a more coordinated way, to support people to live healthier and more independent lives. Patients and carers told us they do not want to have to repeat their story over and over to the different health professionals involved with looking after them. By working across organisational boundaries, patients will benefit from seamless care, with the individual at the heart of it.

Another significant development this year has been our decision to take on more responsibility for the commissioning of primary medical care (GP services) jointly with NHS England. This decision was not taken lightly. We presented our plans to the CCG's Council of Members (made up of all practices) who voted in favour of the

CCG's additional powers and subsequent change to our constitution. We are mindful of the potential for a conflict of interest that comes with this new responsibility. However, we have a robust system of governance and consider joint commissioning to present excellent opportunities to develop general practice and deliver quality care to meet our local population's needs.

Despite the challenging financial environment, the CCG kept within its budget in 2015/16 and this included delivery of a one per cent surplus (£2.2m). This was made possible through the commitment and hard work of our staff and providers who are focused on driving up standards, whilst ensuring services are as cost-effective as possible. Indeed, our staff have done a great job this year and risen to many challenges. They have let us know, via the staff survey, what they think and how we can improve. There is continued confidence in the leadership and over 80 per cent of staff agree the CCG takes positive action on health and wellbeing. We want to build on these results in the year ahead.

Inevitably, there have been a number of farewells and new faces to welcome to the CCG. We would like to pay tribute to Dr Shanil Mantri who stepped down from the Board in March 2016. Shanil has been instrumental in our work over the past few years as a Board member, cluster lead and in his role as Chief Clinical Information Officer working with local providers on joining up patient data across IT systems. Dr Jonathan Osborn has stepped into Shanil's role and helps maintain the clinical balance at Board level. We were also delighted to welcome Katie Hall as a new Associate Lay Member to provide strategic and impartial support to two of our committees.

Collaboration is an important feature of ***your care, your way*** and will be critical to manage demand and shape the future direction of health and care services. We have been working in partnership with the Council for many years and one of our goals is to join up health and care services further. We have also begun working more closely with health and care organisations across B&NES, Swindon and Wiltshire. Together we are taking a 'whole system' approach to identify common challenges and opportunities for working at scale as part of our emerging Sustainability and Transformation Plan.

Finally, we would like to thank all the individuals and organisations that have taken part in consultation and engagement this year and shared their experiences of health and care services. This includes members of our patient engagement group Your Health, Your Voice and ***your care, your way*** community champions. This patient feedback is essential to us to guide our decision-making and help shape the future of local health services.

Tracey Cox
Chief Officer

Dr Ian Orpen
CCG Clinical Chair

Members' Introduction

GPs are the first point of contact with the NHS for most people. They see, listen and respond to the needs and wishes of a wide range of the population on a daily basis.

All GP practices in Bath and North East Somerset are members of the CCG. They are able to share with the CCG the views and feedback of all the health care professions within the surgeries as well as those of the community teams with whom they work. This helps to inform the CCG's strategy and priorities.

In the past year, CCG members have shared their clinical expertise and patient insight with CCG colleagues and partners in order to improve services for the benefit of local people. You can learn about some of the areas where GP involvement has helped make a difference in the following pages of this report. This includes improved access to psychological therapies, a new End of Life strategy, expansion of our social prescribing scheme and tackling the serious problem of antibiotic resistance.

In B&NES our 27 practices are divided geographically into several localities or 'clusters' and in 2015/16 this configuration moved from five to four cluster areas. CCG members meet monthly, altogether and within their clusters to plan and discuss health services. This, together with the fact that six GPs and a practice manager are elected to the Governing Board, has helped ensure the views of the whole health community as well as primary care are taken into account across all areas of the CCG.

It has been a challenging year for everyone in the NHS. But against a backdrop of increased demand on services, contract reviews and constrained budgets, we are delighted that in this year's GP survey, B&NES primary care services were positioned as amongst the best in the country. On page 10 you can read more about the results of the survey, which assesses patient experience of primary care services, and are testament to the hard work and commitment of our member practices.

As the CCG moves forward into its fourth year of operation, it will be more important than ever for all member practices to work together with the public and with the CCG to improve health services and outcomes for everyone living and working in B&NES.

Dr Daisy Curling, Bath Aqua Cluster Lead
Helen Harris, Bath Sulis Cluster Lead
Dr Elizabeth Hersch, Norton Radstock Cluster Lead
Dr Jonathan Osborn, Keynsham and Chew Valley Cluster Lead

Service Update: Reducing the risk of stroke in B&NES

Image – Rev Boots

People with a heart condition called atrial fibrillation have an increased risk of stroke. In 2014/15, B&NES GP practices followed new advice from NICE to offer these individuals anticoagulants (blood thinning drugs) to reduce this risk.

In October 2014, an audit of all GP practices in B&NES revealed 3,525 people with atrial fibrillation who should have been offered these medicines but over a third had not been. Among this 1272-strong patient group, 56 potentially avoidable strokes could be expected each year.

“During the audit, all of the patients who were identified as suitable candidates for oral anticoagulants were reviewed and offered them”, said Elizabeth Beech, a prescribing advisor at the CCG who led the audit with fellow CCG prescribing advisor Clare James.

“After six months, we did the audit again and found that more patients were now prescribed anticoagulants. Nine potential strokes out of the 56 we identified in October 2014 had been avoided”, she added.

As well as showing a reduction in the number of anticipated strokes, the second audit in March 2015 showed that more of the ‘at risk’ patients were now prescribed anticoagulants. The audit will continue to run every six months to make sure patients continue to benefit from anticoagulation and the number of anticipated stokes continues to reduce.

Patient experience with warfarin

We asked a selection of 39 people about their experiences with warfarin to prevent stroke. They reported that having warfarin blood monitoring was reassuring – it meant they knew they were better protected from stroke. The patients also praised the service and care they received from the GP practices.

One B&NES patient, Reverend Claude Boots, has been receiving warfarin treatment for 10 years and doesn’t find it burdensome at all. When speaking to the CCG, he even went as far as to say that it “wasn’t necessarily a bind” to have to go for monitoring even on a weekly or two-weekly basis. At the time of our interview, Reverend Boots was on what he called a “long run” of ten weeks between warfarin monitoring, which contributed to him feeling that his treatment is not a burden.

Key developments and achievements in 2015/16

In the past year we have worked closely with GPs, patients, their carers and other health and social care providers to deliver improved services and develop innovative new models of care. Here we report on some of our initiatives.

1. Community services review - *your care, your way*

your care, your way is a bold and ambitious review of community health and care services for children, young people and adults in B&NES. It is being carried out jointly by the CCG and the Council.

Community services provide care and support in a person's home or a nearby community setting and, together with the Council, we currently commission over 400 different community services from over 60 different providers.

The review was launched at the end of January 2015 and the past 12 months of engagement have helped us to develop a set of shared values and priorities with our local community (see page 28). Our aim is to provide a single care and support plan for everyone using community services where the focus is on overall wellbeing and maintaining independence.

To help us deliver this vision, we began a procurement process in February 2016 to find a prime provider for community services. This will be a single organisation or consortium that will coordinate all care and support in the community and deliver an ambitious set of outcomes for the health and wellbeing of the population. We plan to announce the new prime provider in autumn 2016 with their contract beginning on 1 April 2017. More information can be found at www.yourcareyourway.org

Transforming primary care

In the past year, we have been working with our member practices to explore ways they can provide more services out of hospital and when necessary, offer more appointments at evenings and weekends, seven days per week. Future models of care may include groups of practices working closer together so they can provide a broader range of services and share resources. This work is part of our new primary care strategy to be launched in 2016/17 and is aligned with ***your care, your way.***

From 1 April 2015, we also took on more commissioning responsibility for primary care services, in a joint arrangement with NHS England. Additionally, in the past 12 months:

- We worked with Bath and North East Somerset Enhanced Medical Services (BEMS+) to install a new 24-hour telephone appointment system across 25 of

our 27 GP practices. During December 2015 alone, 5,000 patients used this system.

- We introduced Map of Medicine to all practices during 2015/16. The Map is an online clinical tool that gives access to locally customised pathways and referral forms.
- We launched Consultant Connect. This service provides GPs with immediate telephone access to Royal United Hospital Bath NHS Foundation Trust (RUH) consultants so patients get quicker specialist advice and unnecessary hospital referrals can be avoided.

Our GP practices are among the best in the country

A recent patient survey has highlighted high levels of satisfaction with GP services locally. The GP Patient Survey is an England-wide survey conducted by Ipsos MORI on behalf of NHS England.
3,139 patients completed the survey in B&NES during spring and summer 2015
92 per cent rated their experience of their GP surgery as good (compared to a national average of 85 per cent)
90 per cent were able to get the appointment they needed (national average was 85 per cent)
Satisfaction with out-of-hours' services was lower at 73 per cent but this was still higher than the national average of 67 per cent.

The complete survey results can be found on our website.

Optimising our use of medicines

GPs wrote four million prescriptions, at a cost of £25 million, for people in B&NES during 2015. Our medicines management team works closely with GP practices to make sure these medicines are safe and effective for patients, while providing good value for the NHS.

Some other examples of work by the medicines management team over the past year include:

- Working with GP practices to reduce the inappropriate use of antibiotics, for example for coughs, colds and sore throats. Our GP practices prescribed 4,000 fewer antibiotic prescriptions compared with 2014. We have focused on providing people with clear guidance on what to expect from minor infections, and how to self-care for these infections.
- Reducing the number of expected strokes among patients with atrial fibrillation by implementing NICE guidelines (see page 8 for more about this initiative).

- Our prescribing advisors worked with GP practices and care homes to improve the diagnosis of urinary tract infections in 800 care home residents. This has successfully reduced unnecessary use of antibiotics by 67 per cent and has also reduced hospital admissions for acute kidney injury and sepsis.

Improving the health and wellbeing of children and young people

In the past year we have worked closely with the Council to support children and young people in B&NES. There have been a number of developments during 2015/16:

- We updated our emotional health and wellbeing strategy for children and young people so it aligns with the suicide prevention strategy. The Children's Trust has approved these plans.
- Our Children and Adolescent Mental Health Services (CAMHS) Transformation Plan was approved by NHS England resulting in £333,000 additional funding for services in 2015/16. This investment is helping to improve the specialist eating disorder service and to train teaching and care staff to better identify and support children and young people with mental health issues.
- Our work to support children with complex needs was showcased at the National Integrated Personal Commissioning Conference in early 2016. This includes a pilot scheme to help people with complex conditions to plan short breaks.

Service update: Personal Health Budgets

Image – Sally Beckley Fun Fit Club

The NHS provides 'continuing care' for people who have needs arising from a disability, illness or injury that cannot be met by existing, universal NHS services. Since April 2014, any child or young person eligible for continuing care has had the right to access a direct payment called a personal health budget. So far in B&NES, there are eleven children and young people who have received these budgets.

One particular B&NES case highlights the improvements that personal health budgets can make to patient outcomes, as well as the bespoke nature of care that can be designed.

"This child had been receiving continuing care for eight years to support her with a tracheostomy and a gastrostomy feeding tube. It became clear that while there were no problems with the service, it was no longer meeting all of the child's desired outcomes," said Sally Beckley, the Children's Continuing Care Nurse Manager for BaNES CCG.

The girl's family chose to reduce her level of care overnight. They have set up a shared budget held by the child's school to employ school carers, and they receive a personal health budget that pays for a carer to accompany the girl in activities that increase her independence. As well as meeting the child's needs more effectively, the change in care package has saved approximately £25,000.

Personalised budgets for group activities
The reach of personal health budgets is also being extended to adults and children in the community. One such project is the Fun Fit Club, which is held at Threeways School in Bath. The club is a collaboration between the school, public health nurses from Sirona care and health, Bath Rugby Foundation, Sainsbury's (business) and is funded through the CCG.

Participants are allocated small personal health budgets to pay for activity tracker watches, which encourage and monitor activity levels while they are on the course. The club is a good example of how working across sectors in a person-centred way can make a real difference to supporting people's outcomes.

Key developments and achievements in 2015/16 cont

Joint working with the Council to focus on learning disabilities services
We worked with the local Autism Partnership Group to review our autism strategy. Engaging with this group on our action plan has been a successful start to more long-term collaboration. A future priority includes making sure people with autism receive support to find and stay in work. We commissioned the National Development Team for Inclusion to work with staff to better support young people moving into adulthood. Young people with an Education Health and Care plan are now encouraged to get fully involved in their transition assessments and planning.

We have continued to work with young people and their families as they move into adulthood to identity the right housing and employment support. In 2015/16 this included support to individuals to buy their own home through a shared ownership scheme and increasing take-up of the local Shared Lives Scheme which supports people to gain independent living skills. We agreed local procedures for ensuring that all adults can access advocacy support if required in line with the duties of the Care Act 2014. We improved access to and uptake of three national health screening programmes for bowel cancer, diabetic eye and abdominal aortic aneurysm (AAA). Community Learning Disability Nurses (CLDNs) have produced easy read support materials. They are notified when an individual with learning disabilities is invited for screening so they can provide support throughout.

Integrated, coordinated mental health services
People in B&NES continue to benefit from well-coordinated mental health and care services thanks to effective partnership working between and local organisations.

This will continue as we develop our ***your care, your way*** community services model.

Wellbeing House - This year we opened the Wellbeing House in Bath, supported by Sirona care and health and Curo – a local housing organisation. To date, 50 people have been referred to the service. For more information, read the case study on page 15.

Local alcohol services - B&NES' investment in local alcohol services has attracted a good deal of worthy commendation for its hospital alcohol liaison service, and for alcohol recovery outcomes.

Social prescribing - The *My Script* social prescribing service has been in place since April 2015 and supported more than 280 clients in its first year. A social prescription is an intervention that identifies and addresses underlying needs such as debt, isolation, housing issues or relationship problems which can fuel frequent GP attendance. The service is provided by Developing Health and Independence (DHI), a local charity that supports people who are socially excluded for reasons including homelessness, drug and alcohol problems and learning disabilities.

Service update: High chance of recovery with B&NES Talking Therapies

Image – Wellbeing House entrance

During 2015/16, B&NES' Talking Therapy service had some of the highest rates of recovery in the country. Over 60 per cent of people who are treated by the service go on to recover, compared with a national average of 45 per cent.

The service is funded by the CCG and provided by AWP. It offers patients an initial assessment appointment to determine the best course of action, which might include one-to-one treatment or a free psycho-educational course.

Waiting times for the service are also excellent, figures from the start of 2015 show that our region is ranked fifth in the country for patients waiting less than 28 days for an initial assessment. Better still are our treatment waiting times, with 86 per cent of our patients waiting less than 28 days to be treated, putting us in the top three NHS areas in the country.

"These figures are something to be really proud of, as they reflect not just the quality of the service we provide, but the commitment of the staff team who provide it", said Ursula James, Clinical Lead for the Talking Therapies service.

In the November 2015 – January 2016 period, patients made comments such as: "It has made a huge difference to my life. I am extremely grateful." "The course was very helpful and informative and has helped me very much on my road to recovery."

Wellbeing House
The Wellbeing House is an innovative service giving a temporary retreat for those experiencing mental health distress in B&NES. It is run by Sirona care and health in partnership with Curo.

“It is a non-clinical service where it is vital that individuals are listened to, treated as equals and not judged,” says Sirona’s head of mental health services, Paul Wilson.

One user said: *“I feel quite emotional as I am writing this as the Wellbeing House has quite possibly saved my life. Being here provided a sanctuary and safe haven for me with no pressure to have to cope with anything alone. The house and staff have made me feel welcome and I have felt I can talk openly about my fears and worries without being judged. From the bottom of my heart I thank you.”* – Individual who stayed at the Wellbeing House, December 2015.

Key developments and achievements in 2015/16 cont

The Better Care Fund aims to deliver more joined up and appropriate care for the people of B&NES. NHS and social care services are now caring for people with increasingly complex needs and multiple conditions. We need to do things differently to make sure we can provide the best care both now and in the future.

The best way to deliver care is to organise it around the person who needs it, and that person’s care team should work together to support them to stay healthier for longer. Every different service should work seamlessly together, with no gaps or unnecessary delays. The Better Care Fund helps make this happen with pooled budgets and much closer working relationships. It is ultimately better for people and better for professionals.

The key priorities of the Better Care Fund are:

- seven-day working
- protection of adult social care services
- integrated reablement and hospital discharge
- admission avoidance
- early intervention and prevention

One of the initiatives being funded by the Better Care Fund is social prescribing, see above (page 14) for more about this.

End of Life Care
In 2015/16 we have improved care for people at the end of their life, with a new End of Life Care Strategy, supported by end of life care plans and treatment escalation plans in place in hospitals and in the community. This strategy was developed by

CCG commissioners working in collaboration with the GP clinical lead Dr Elizabeth Hersch and public health colleagues.

Several of our projects feature as service updates throughout our annual report. These are; reducing risk of stroke in patients with atrial fibrillation (page 8), personal health budgets (page 12), excellent recovery rates with B&NES Talking Therapies (page 15), commissioning for carers (page 20), tackling an increased demand for urgent care (page 23), and pharmacists support to primary care (page 38).

How we progressed with our six transformational projects

2015/16 is the second year of our five year strategy, *Seizing Opportunities*, to improve health outcomes and the quality of health and care services for the people of B&NES. Here we update on progress with the six transformational projects we set out in our strategy, which are also in line with NHS England's *Five Year Forward View*.

Prevention, including self-care
BaNES CCG wants all health and care organisations to support people to take greater responsibility for their own health and wellbeing, particularly those who live in areas where there are greater health inequalities.

In 2015/16, we continued to work with our partners to expand existing prevention programmes and deliver new projects such as a self-care package for frequent A&E or urgent care attenders. National campaigns such as flu vaccinations, smoking cessation and 'One You' were promoted across a number of local organisations. As life expectancy improves for our local population, there is a group of men for whom this is not true. As part of the Personal Medical Services (PMS) Review we have committed to invest in practices with poorer health outcomes to focus primary and secondary care initiatives for this group.

Improving diabetes care
The way we treat patients with diabetes (the diabetes care pathway) has been redesigned in order to meet the increasing numbers of people with Type 2 diabetes. The new pathway aims to deliver as much care as possible out of hospital but with robust support from specialists.

In 2015/16, we completed the roll-out of a new community diabetes multidisciplinary team (including a consultant diabetologist, specialist nurses and lead GP) across five practices. This scheme will expand across the other 22 practices in B&NES in 2016/17.

We also piloted a local enhanced service (LES) to enable GPs to visit housebound patients to assess their risk of developing diabetes or check up on how they are managing the condition. This initiative will be reviewed, with the intention of expanding it to other practices. We also developed a supported self-management strategy in 2015/16, and will begin implementing it in the coming year.

Musculoskeletal service review and redesign
With an aging population, we are seeing increasing numbers of patients that have musculoskeletal issues that include problems with joints, the spine, ligaments and nerves.

The new 'hip and knee' pathway, developed by clinicians and commissioners, helps patients to recover quickly from joint replacement surgery and reduces their hospital stay by supporting them to take responsibility for their own rehabilitation and pain management.

This pathway is estimated to have saved nearly £960,000 over the past two years as more patients take responsibility for their recovery and the need for follow up hospital procedures is reduced.

In 2016/17, we plan to expand the 'hip and knee' pathway to see more patients and begin work on a new community based musculoskeletal service that is in line with the ***your care, your way*** community services review.

Joining up our information systems
We want to improve patient experience by connecting up the different IT systems used by our partners to hold patient records. This means people would not have to remember and repeat their medical history each time they receive treatment and care. We have looked at using an IT system called Connecting Care to join up records.

Over the past 12 months, we have worked closely with our key providers to develop our interoperability systems locally. Early in 2016, it became evident that not all our partners were confident that Connecting Care was the right scheme for B&NES.

Our priority will now be to explore how we can maximise the benefits of upgrading and improving our existing local and national information-sharing systems such as the summary care records used by GPs. We will also develop a Digital Roadmap setting out how we will achieve the ambition of being 'paper-free at the point of care' by 2020.

Improving urgent care
We want to improve access to timely, quality urgent care services for all and ensure patients are treated by the right person in the right place, at the right time.

In 2015/16, we have seen a steady increase in the number of emergency admissions and have not achieved the national target for 95 per cent of patients in A&E to wait less than four hours to be seen.

Our System Resilience Group (SRG) includes senior representation from all key partners and is chaired by Dr Ian Orpen. The group has continued to focus on initiatives that support admission avoidance and improve discharge processes such as 'discharge to assess' and 'Home for Christmas'. You can find out more about these on page 23.

A key priority for 2016/17 is to develop alternative community-based services that will help reduce emergency care activity and pressures on the RUH.

Person-centred care for frail, older people
Older people should feel valued, respected and supported to stay well as long as possible and lead fulfilling, happy and safe lives. To help achieve this, we have been joining up health and social care services to make them more accessible to older people.

The 'hale and hearty' pilot scheme, in collaboration with Age UK, identified people aged over 85 living alone with little or no help. Trained volunteers arranged home visits to see whether there was any support needed to help these older individuals remain independent at home.

We have also led on a number of initiatives to improve the quality of care for residents in care homes and you can read more about this on page 40.

You can read more about our core projects and priorities for 2016/17 in our one-year operational plan (to be available on our website in May 2016). Our five-year strategy is available on our website at www.banesccg.nhs.uk.

Service update: Celebrating commissioned services for carers in B&NES

Image – Carers' Centre pic

Services for carers in B&NES are provided by the CCG, Council and B&NES Carers' Centre, which is an independent charity providing free support in the local community, including advice, counselling and respite.

In September 2015, the service we commission for carers in collaboration with the Council was nominated for a prestigious award by the Health Service Journal.

The Carers' Centre is often referred to by their clients as a 'lifeline'. Things that seem simple enough like having time to yourself, talking to someone, or even just being able to get out of the house can be insurmountable tasks for some carers.

"In B&NES, we know that carers of all ages are invaluable. Therefore, we have a well-established commitment across the NHS, primary care, B&NES Council and voluntary sector to support them to carry out their vital role and improve their quality of life", said Sonia Hutchison, the Carers' Centre Chief Executive Officer.

B&NES' services for carers were shortlisted for a Health Service Journal Award in the category of 'CCG Commissioning for Carers'. Despite not winning, the nomination highlighted the crucial relationships that exist in our area, as well as the successful approach to commissioning.

Empowering stakeholders
A core approach adopted by the Carers' Centre is to consult with carers regularly. At the moment, a project is underway to update the B&NES Carers' Strategy, to make sure that it is a true reflection of their needs.

"A process of consultation with carers has taken place to gather the key areas that local carers want to see in the strategy, which is now in the process of being pulled together. This is happening hand in hand with ***your care, your way*** which is redesigning all health and social care services", said Sonia.

About Us

Our population

There are 182,021 residents in B&NES[1]. There is a significantly higher proportion of residents aged 20-24 years than there is nationally, at 11 per cent versus 8 per cent, which can be attributed to the high student population.

There is significant variation in population density between areas in B&NES, ranging from 51 people per square kilometre in Corston to nearly 10,000 for Oldfield Park West in Bath.
B&NES is less ethnically diverse than the UK as a whole, with 90 per cent of local residents defining their ethnicity as White British. This is followed by almost 4 per cent who define themselves as White Other and 1 per cent who define themselves as Chinese.

Our population is growing
The overall population of B&NES is expected to increase to nearly 200,000 by 2024, an increase of 11 per cent from 2014.

Our population is changing
Population projections suggest that there will be large increases in the number of older people in B&NES. For example, by 2021 the number of over 75s in the population is projected to increase by 20 per cent (approximately 4,400 people) and the number of over 90s is projected to increase by 44 per cent. These increases will mean that services for older people are likely to experience increases in demand.

Significant health factors
Whilst life expectancy is higher than the regional and national averages, it falls significantly for people living in the most deprived areas of B&NES. So although the people of B&NES are relatively healthy, there are avoidable differences in health outcomes between different sections of our population. Hospital admissions for alcohol in the under 18s, for example, have risen in recent years and the number of people smoking, although lower than the national average, is still higher than we would like. Conditions such as these are a major risk factor for a number of causes of death and disability and so remain a priority.

Challenges in our operating environment

Whilst we are mindful of broader social, economic and environmental challenges facing B&NES, specific challenges to our role in commissioning health and care services include:

[1] Population estimate provided by the Office for National Statistics 2015.

Demand: similar to the national picture, we are experiencing pressure on all services locally but there is particular pressure on emergency, and some elements of planned hospital care.

Performance: we have seen a sustained failure to meet the A&E four-hour waiting time targets at our main provider, the RUH. We continue to see variable achievement of 'Referral to Treatment' times and in the latter part of the year, there have been specific local workforce issues which have impacted on waiting times for patients with breast symptoms, not suspected to be cancer. The CCG is working with the RUH to resolve the issues that are impacting on the Trust's ability to deliver these constitutional standards. Our overall annual performance for category A (red 1 and 2) ambulance response times has also fallen short of national targets and we are working with South West Ambulance Service Trust (SWAST) to deliver improvements.

Quality and safety: we must ensure health and care services continually improve their quality and are delivered safely, whilst at the same time ensuring we work within our financial allocation to manage the demand for these services.

Finance: 2015/16 was a financially challenging year for us. We ended the year by delivering the target surplus set for us by NHS England. However, in order to fulfil all the ambitions of next year's operational plan and continue to achieve a one per cent surplus year-on-year, we need to have plans to address an emerging financial gap.

Service update: Tackling increased demand for urgent care

During 2015/16, an average of 88 per cent of patients were seen by the A&E team at the RUH within four hours. This falls short of the national target of 95 per cent.

Increased demand for urgent care is largely due to an increase in the number of elderly people presenting at A&E with complex medical conditions that require a longer stay in hospital. There have also been some delayed transfers of care. Some patients have not been able to be discharged from hospital because they are waiting for assessments and arrangements to receive care closer to, or at home.

Improving our urgent care performance

In October 2015, the local System Resilience Group (SRG) undertook a whole-system review with the help of NHS England's Emergency Care Intensive Support Team (ECIST). They developed a four-hour recovery programme to strengthen urgent care performance and maintain high quality patient care. This programme has recently been refreshed.

One new initiative that is part of the recovery plan is to create an integrated discharge team at the RUH. This team comprises health and social care professionals to encompass patients' broad healthcare needs. The goal is to get patients home more quickly, with the appropriate level of support to ensure they

make a good recovery. . These arrangements have also been supported by a further increase in ‘Discharge to Assess’ capacity, enabling patients to be assessed for their on-going care needs in their normal place of residence as opposed to a hospital setting.

‘Home for Christmas’ was a system-wide initiative to increase patient flow through the RUH. Patients benefited from a timely, effective and safe discharge and pressure on beds was eased over the Christmas period by creating additional capacity. The initiative was led by the CCG with the support of the SRG. By midnight on Christmas Eve, just over 30 per cent of beds were unoccupied at the hospital.

We are also working with commissioners and providers at a regional level to establish an integrated clinical hub. Doctors will provide specialist advice and guidance to NHS111 and 999 call handlers and thereby reduce the number of urgent enquiries requiring referral to A&E. The CCG is also working in partnership with the RUH to develop ambulatory care services on the RUH site and facilitate safe same-day discharge for patients attending A&E.

Collaboration with partners and providers

We seek to improve health outcomes and the quality of health services by working in partnership with others. We have joint commissioning arrangements with B&NES Council and have combined our mental health and learning disabilities budgets. To strengthen joint working across the CCG and the Council, some commissioners and a finance lead are funded jointly by both organisations. We also work in partnership with the public health team at the Council to tackle health inequalities and promote healthy lifestyles.

In November 2015, we held a joint event for Council and CCG staff to start exploring how we can further pool resources and make services even more joined up.

The CCG’s Clinical Chair Ian Orpen co-chairs the local Health and Wellbeing Board alongside B&NES Council Cabinet member for Adult Social Care and Health. Our Chief Officer and Lay Member for Audit also represent the CCG on this Board, with the aim of improving the health and wellbeing of the local population and reducing health inequalities.

The local Health and Wellbeing Board was shortlisted in the Local Government Chronicle Awards 2015. This was for having a clear and ambitious vision to deliver outstanding health and care for local people and commitment to tackling the difficult issues faced locally around health inequalities and pressures on urgent care.

During 2015/16, we have provided update reports at every meeting of the Health and Wellbeing Select Committee. This panel reviews and scrutinises the work of the CCG, Council and other organisations in relation to health and wellbeing as well as

examining issues that impact on the local population with a focus on community health and safety.

In addition to managing and monitoring contracts, we work with providers to review and develop plans for high quality services and to respond to seasonal pressures on hospital services. Key providers that we commission services from are:

- Royal United Hospitals Bath NHS Foundation Trust (RUH)
- Sirona care and health (an independent community interest company providing integrated community health and social care services)
- Avon and Wiltshire Mental Health Partnership NHS Trust
- Bath and North East Somerset Doctors Urgent Care
- University Hospitals Bristol NHS Foundation Trust (UHBT)
- North Bristol NHS Trust (NBT)
- South Western Ambulance Service NHS Foundation Trust
- Care UK which provides NHS111 services
- B&NES Enhanced Medical Services (BEMS+)
- Voluntary and community organisations such as Age UK and The Alzheimer's Society
- Nursing and residential care homes
- Hospice care including Dorothy House Hospice and St Peter's Hospice
- Local independent providers including BMI Bath Clinic and Circle Bath.

We also work collaboratively with our neighbouring CCGs. In particular, 2015/16 has seen us begin to plan a joint Sustainability and Transformation Plan with Swindon CCG and Wiltshire CCG.

NHS South, Central and West Commissioning Support Unit help us deliver our commissioning functions and NHS England oversees the health system nationally and holds us to account.

Our vision and values

The CCG has six core values that inform everything we do:

- focus on continually improving the quality of services
- be credible, creative and ambitious on behalf of our local population
- work collaboratively and be respectful of others
- stay focused, committed and hardworking
- be alert to the needs of our population, particularly those who are most vulnerable
- to operate with integrity and trust.

Our strategic objectives

Our strategic objectives are to:

- improve quality, safety and individuals' experience of care

- improve consistency of care and reduce variation of outcomes
- provide proactive care to help people age well and to support people with complex care needs
- create a sustainable health system within a wider health and social care partnership
- empower and encourage people to take personal responsibility for their health and wellbeing
- reduce inequalities and social exclusion and support our most vulnerable groups
- improve the mental health and wellbeing of our population.

Consulting with and involving the public

We believe that involving patients, service users and carers in the commissioning process means that health services are better designed to suit their needs.

Members of the public are welcome to attend our Board meetings in Public and our Joint Co-Commissioning Committee, which focuses on primary care services. We invite questions from the public at all meetings in public and have started to encourage questions through our Twitter newsfeed. We regularly invite patients to share their personal experiences of health and care at the beginning of our Board meetings.

Our Your Health, Your Voice group meets every two months, providing an opportunity for the public to raise their own agenda items, discuss services and feed into our plans to improve local health services. The group supports our public and patient involvement work on commissioning issues and acts as a critical friend to the CCG in terms of reviewing proposed service changes and new commissioning strategies. These meetings are driven by the public and are supported by a larger body of associate members who participate virtually and attend meetings when they are able to.

The meetings are chaired by Suzannah Power, the CCG's Lay Member for Patient and Public Involvement, who gives a report on the feedback received at every Board meeting. Suzannah's role is to champion patient and public engagement. She brings her wider patient perspective to influence and improve the way we commission and deliver services. You can read more about Suzannah's background on page 60.

Public involvement underpins the commissioning role of the CCG and during 2015/16 there was active engagement as part of the ***your care, your way*** community services review (see pages 9 and 28).

The CCG's refreshed communications strategy for 2015 – 2017 was approved by the Board in July 2015. This strategy has a strong focus on public consultation and involvement at every stage of the commissioning cycle, as well as ensuring

communications activity is accessible and relevant to vulnerable groups. During 2015/16, we redeveloped the CCG's website to improve navigation and content. We also began to engage with stakeholders using social media, including Twitter, Facebook and LinkedIn.

Wider stakeholder engagement

We are committed to understanding the need, interests and expectations of our stakeholders in order to build trust and establish strong relationships. The Ipsos MORI 360° stakeholder survey is commissioned annually by NHS England and helps us to monitor that these strong relationships are in place.

Results shared with us in May 2015 demonstrate that overall, there is a good level of engagement and confidence in the CCG. A total of 93 per cent of respondents rated their working relationship with us as very or fairly good, and the majority (81 per cent) said they understand our plans and priorities. The CCG has improved in both these areas in the past 12 months suggesting that we are improving relationships with our stakeholders.
There is extremely high confidence that improving patient outcomes is a core focus for the CCG with 98 per cent of stakeholders strongly agreeing or tending to agree with this statement. This positive response suggests we are communicating our vision effectively.

However, less than half of respondents (45 per cent) agreed or strongly agreed that our plans will deliver continuous improvement in quality. Furthermore, confidence in the CCG's leadership to deliver its plans and priorities has fallen in the past year from 80 per cent in 2014 to 67 per cent in 2015. A number of stakeholders raised concerns about the CCG's capacity constraints and workload which may help explain the low score in these areas.

The survey results indicate very good working relationships with the local council but there is scope to increase the proportion of stakeholders, particularly amongst GP members, who feel consulted regarding decision making. There has been a significant increase in the overall percentage of respondents who understand the reasons that inform the CCG's commissioning decisions (43 per cent in 2014 rising to 67 per cent in 2015), but only 47 per cent of GP members feel involved in the CCG's decision making process.

The full report and action plan are available on our website.

Service update: *your care, your way*

2015/16 has been a year of continuous engagement, consultation and dialogue with our stakeholders. Working in close partnership with the Council, we have actively sought the views of the people who use our services and the people that provide them.

Our joint review of community health and care services, ***your care, your way***, has been a catalyst for challenging existing attitudes to health and care. People have told us they want to be treated as a person, not a problem to be fixed, with a single care and support plan that places equal importance on their physical, mental and emotional health. People want to take better care of themselves and each other, but they need a helping hand from us in order to do that.

We have taken a proactive approach to engagement, actively seeking out existing local groups with an interest in local health and care services. We have taken part in over 80 separate events ranging from the Primary School Parliament to the Bath Ethnic Minority Senior Citizens Association and from our Design Day at Bath Racecourse with over 100 people to a cosy chat at the 'Hub in a Pub' in Chew Stoke.

We chose to use digital channels as our principle method of communication. This has allowed us to reach large audiences for minimal cost whilst providing the data we need to evaluate the effectiveness of our campaigns. A total of 84 per cent of the consultation responses were collected online, our best performing tweet was seen by over 2,721 people and our microsite received 2,348 visits during the seven-week formal consultation period.

One of the highlights of our engagement work this year is the Design Day at Bath Racecourse in May. This event brought together over one hundred service users and patients, carers, GPs, front line workers, senior managers and third sector organisations to learn from each other and think creatively about how services could be delivered in the future.

We received 183 responses to our workforce survey in July and our public consultation on the vision, models and priorities for community services ran for seven weeks and received 545 responses.

To see the full summary of what people told us visit www.yourcareyourway.org where you will find over 50 event reports alongside our full Phase One and Phase Two engagement reports.

Our staff

Our talented and diverse workforce is integral to the CCG's success. Our employees are a vital asset and play a critical role in ensuring we achieve our vision for everyone to live happier and healthier lives.

In the past year there have been a number of organisational developments. For example, we have invested in additional staff resource for our commissioning, programme management office and quality teams.

How we engage with staff

In 2015/16, we have developed and implemented a plan to tackle areas of weakness following the results of our 2014 staff survey. Actions resulting from the survey included a review and redesign of our intranet and website, setting up a social

committee, establishing a staff wellbeing group and improving the working environment.

In November 2015, the survey was repeated and two-thirds of staff took part. It revealed continued high levels of confidence in the executive leadership of the CCG as well as our commitment to improving the quality of NHS services.

More staff reported using the intranet regularly compared with the previous year's survey, and more reported finding the intranet easy to use. This could be a positive result of the redesign of the intranet in summer 2015. The figure for intranet use remains relatively low however, so we have planned intranet training programme in summer 2016 to ensure staff are able to make the most of this key engagement tool.

Training and development
Results from the staff survey reveal that three-quarters of staff feel encouraged to develop their skills and abilities, which indicates good opportunities to take up development opportunities. Staff have taken advantage of various in-house and external opportunities through the year, one notable session held at the CCG was a report-writing course, which brought together staff from all levels of the organisation.

Wellbeing group
The CCG's Wellbeing Group meets every quarter to discuss ways to improve staff wellbeing and create a better office environment. It includes representatives from every team within the CCG. The group was set up after the 2014 Staff Survey found that staff felt under a lot of pressure and were dissatisfied with their working environment.

So far, the Wellbeing Group has funded new door signs and organised a 'declutter day' to tidy up the office and dispose of old records. In May 2016, the group has funded CCG staff to enrol in the Global Corporate Challenge. This 100-day challenge will see teams of seven competing with each other (and teams around the world) to increase the number of steps they take each day, as well as making improvements to their nutrition, sleep and mental wellbeing.

Celebrating staff success
One of our senior commissioning managers, Andrea Morland, was shortlisted for a NHS South West Leadership Academy award in 2015. Alice Harding also joined us as an apprentice. Alice has successfully completed her secretarial qualification and continues working with us in the administrative team.

How we measure our performance

Performance standards are delivered through the service contracts we hold with all local health organisations providing NHS services. We meet regularly with these and

other providers to review delivery of national and jointly agreed local measures to help ensure services perform well and meet the health needs of our local population.

We are required to report on some key national health targets and work closely with the NHS England to ensure our performance is in line with or exceeds these targets. Additionally the NHS England assurance framework measures our performance in six key areas or 'domains' and we meet quarterly with NHS England to discuss our progress.

In September 2015 the NHS Atlas of Variation was published. This compendium atlas is the largest yet, with 102 maps detailing widespread variation in the quality, cost, activity and health outcomes in England. We use this and other benchmarking tools such as the CCG Commissioning for Value Toolkit to help us identify priority areas to improve performance.

During 2015/16 we have also introduced an internal operational assurance framework to track planning and delivery of key projects and help ensure any issues are identified early. We present bi-monthly an integrated quality and performance report and dashboard at our public board meetings that includes local progress against key national targets, public health and patient engagement indicators. We also update the Board on actions completed or underway to resolve poor performance and mitigate risks.

B&NES ranks top for preventing people from dying prematurely

Data released in September 2015 that measures the number of years of life lost (per 100,000 registered patients) from conditions that are usually treatable, highlighted that we are the best performing CCG in England.

The data is collated as part of the NHS Outcomes Framework, a set of 68 indicators to measure performance in the health and care system at a national level. These indicators are grouped into five domains and the first of these is around preventing people from dying prematurely. The latest results show that our region has the lowest number of deaths that could have been avoided if effective healthcare had been provided (recorded as potential years of life lost or PYLL) and we perform particularly well for preventing premature death from respiratory and heart disease.

Progress against key targets

Our Annual Report highlights a number of achievements this past year including Talking Therapies, stroke prevention and reducing the inappropriate prescribing of antibiotics. Additionally, we are required to report on some key national health targets and work closely with the NHS England area team to ensure our performance is in line with or exceeds these targets.

Urgent care targets

Below is a table summarising our urgent care performance against NHS Constitution targets. Please note A&E performance is at Trust level rather than CCG and the RUH results are shown here.

NHS Constitution Standard	Target	2015/16		Commentary
% of A&E attendances taking under 4 hours (RUH)	95%	87%	R	This result is for the RUH because combined provider scores are not available for A&E attendances. The urgent care system both locally and nationally has been challenged throughout the year. The RUH has experienced capacity issues with planned bed closures during the summer and ward closures due to Norovirus and Flu during the second half of the year. Pressure on the system has remained high, with high levels of non-elective admissions and difficulty maintaining flow in the hospital through timely discharges. The System Resilience Group (SRG) are leading the implementation of a recovery plan.
Ambulance - category A (red 1) - % attendances within 8 minute response time	75%	72%	A	The number of ambulance incidents has been higher than expected throughout the year. This is placing significant pressure on response time targets. The involvement of South Western Ambulance Service Foundation Trust (SWASFT) in the national Ambulance Response Programme has been assessed as reducing Red 2 performance by 5%. SWASFT and NHSE have therefore agreed a 5% offset in the Red 1 target to 70% from 75% nationally. Performance has also been impacted by the introduction of a new service-wide Computer Aided Dispatch system. Commissioners and SWASFT have agreed an improvement plan and work on improvement measures is ongoing.
Ambulance - category A (red 2) - % attendances within 8 minute response time	70%	65%	R	
Ambulance - category A19 - % attendances within 19 minute response time	95%	90%	A	

Planned care – access to treatment

The RUH is our key provider of acute services although some patients in B&NES will use Bristol hospitals run by University Hospital Bristol NHS Foundation Trust and North Bristol NHS Trust. The Bristol hospitals also provide specialist services not available at the RUH. For certain referrals patients can also choose to be treated by independent providers such as Circle Bath hospital, BMI Bath Clinic, Emersons Green Treatment Centre and Shepton Mallet Treatment Centre.

Below is a table summarising our planned care and referral to treatment time performance.

NHS Constitution Standard	Target	2015/16		Commentary
Diagnostic test waiting times - under 6 week waits	99%	98.9%	A	Diagnostic performance has been very good but dropped below 99% over the winter as a result of sustained high activity and capacity issues in a number of test types, notably sleep studies, echocardiography and endoscopy.
Cancelled Operations - not rebooked within 28 days (RUH)	1%	0.9%	G	The percentage of cancelled operations not rebooked with 28 days was above target in the first half of the year and below for the second half. Performance has improved substantially on last year.
Referral to Treatment Times				
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	90.7% (Year-end)	R	Although this standard was below target at year end, it was achieved for 9 months of the year. The total number of people on an RTT pathway who have been treated was 4% higher than last year and the increased demand has led to the waiting list at the end of March 2016 being 15% larger than March 2015. Commissioners are working with the RUH to support recovery to a stable position in 2016/17.
Number of 52 week incomplete referral to treatment pathways	0	64	R	This measure is a sum of the number of people who had been on an incomplete pathway for 52 weeks or more in each month of the year. There was a peak of 9 incomplete 52 week waiters in June, which has reduced to 5 by year end. Throughout the year, two of the 52 week waiters were at the RUH and the remainder were at the North Bristol Trust (NBT). NBT are working through a significant backlog in spines surgery. This is the regional specialist service and similar pressure is being felt elsewhere in the country. Recovery plans are underway.

Cancer care – access to treatment

Cancer diagnostics and treatment is provided by RUH, North Bristol NHS Trust and University Hospitals Bristol NHS Foundation Trust. There are nine indicators to meet for access to cancer treatment, depending on the access route, stage of illness and the treatment needed. Sometimes very small numbers of patients go through these pathways and not every target will be met every month.

We have achieved the majority of key targets set both nationally and locally during 2015/16.

The below table summarised our performance against cancer waiting time standards

NHS Constitution Standard	Target	2015/16		Commentary
All Cancer 2 week waits	93%	94%	G	Performance on this key indicator has generally been strong. Quarter 2 saw a short-term drop below target due to a significant increase in referrals following new NICE guidance to GPs aimed at increasing early diagnosis. However, performance in the second half of the year was the best for a 6-month period in two years, in spite of ongoing high referrals.
Two week wait for breast symptoms (where cancer was not initially suspected)	93%	87%	R	This indicator has failed since December 2015 due to shortages of specialist staff at the RUH. Recruitment of breast radiologists remains problematic and the RUH are updating the Recovery Action Plan to reflect these difficulties. Continuous audit since December confirms 95-98% of all cancers were seen and diagnosed within 2 weeks of referral.
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	99%	G	This indicator has performed on target in every month of 2015/16.
31-day standard for subsequent cancer treatments-surgery	94%	98%	G	This indicator has performed on target in every month of 2015/16.
31-day standard for subsequent cancer treatments-anti cancer drug regimens	98%	100%	G	This indicator has performed on target in every month of 2015/16 and has been at 100% for the last 26 months.
31-day standard for subsequent cancer treatments-radiotherapy	94%	100%	G	This indicator has performed on target in every month of 2015/16 and has been at 100% since May 2015.
All cancer two month urgent referral to first treatment wait	85%	88%	G	Performance for this indicator has been variable, with the target achieved for 7 of the last 12 months. In total through the year there were 60 breaches of the waiting time target out of 495 patients treated.
62-day wait for first treatment following referral from an NHS cancer screening service	90%	93%	G	After variable performance in the first half of the year, this indicator has improved to a sustained good position. There are generally small numbers of people on this pathway with 7 breaches out of 102 people seen in the year.
62-Day wait for first treatment for cancer following a consultants decision to upgrade the patient's priority	90%	100%	G	There have been no breaches on this pathway in 2015/16

Other national priorities

Dementia

In 2015/16, we achieved our locally agreed dementia diagnosis rate most months. This target requires us to ensure two thirds (67 per cent) of all people estimated to have dementia in B&NES receive a formal diagnosis. The local dementia care pathway group have created a local action plan that sets out our aspirations in line with the Prime Minister's Challenge on Dementia 2020.

Heart Failure

There was an increase in referrals in 2015/16 for the community echo-cardiology clinics, which has resulted in waiting lists increasing and breaching the six-week diagnostic target. We have approved extra investment for 2016/17 to help meet the additional demand and will continue to monitor update of heart failure services.

Long Term Conditions

NHS England provides the CCG with support, tools and packs of data to help them know 'where to look' as a first stage to identify real opportunities to improve outcomes and increase value for local populations. The latest 'Commissioning for Value: Where to look' information pack was published in January 2016 and B&NES compared well to similar CCGs for long term conditions. We have lower mortality rates than comparable CCGs for neurological conditions, circulatory diseases, respiratory diseases, cancer, gastrointestinal problems and trauma. We need to improve early identification and outcomes for hypertension and cholesterol.

National Indicators	Target	2015/16		Commentary
Estimated diagnosis rate for people with dementia	66.7%	65.9%	A	This initiative is focussed on ensuring everyone with dementia has a diagnosis and receives appropriate treatment and support. Following the significant progress in 2014/15, the BaNES diagnosis rate has remained on or close to the national target of 66.7% throughout 2015/16.
Improving access to psychological therapies	15%	18%	G	This indicator measures the number of people who access community psychological therapies as a proportion of the total number who may have mental health issues. This is an area that BaNES focussed on heavily in 2014/15 and the local service continues to perform well.
Recovery following talking therapies for people of all ages	50%	61%	G	Of the people who access psychological therapies in the community, this measures the proportion who are moving to recovery when discharged (based on set criteria). This indicator improved significantly toward the end of 2014/15 and has performed above target throughout 2015/16.

Better Care Fund performance

For 2015/16 we had a Better Care Fund budget of £12.049 million, which was used to fund a range of integrated services, including services that enable people to take control of their lives, receive care and support in their homes and communities, remain as independent as possible while having good quality of life.

We met our targets with regards to admissions of older people into residential and nursing care but missed them for overall non-elective admissions into hospital among all age groups. The table below indicates our performance against national targets:

National Indicators	Target	2015/16		Commentary
Total non-elective admissions in to hospital (general & acute), all ages	15,358	15,972	R	Significant pressures on the local urgent care system mean that our non-elective admissions target is proving challenging to achieve. The SRG are leading the development and implementation of a whole-system recovery plan. 2015/16 admissions were 4% above target and 3% above 2014/15. There was however a 2.2% reduction in admissions for those aged 75 and over. This is a positive reflection of the Better Care Fund (BCF) schemes that targeted the over 75's population in BaNES.
Delayed transfers of care (DTOCS) from hospital (delayed days), people aged 18+	4,200	4,193	G	DTOC days for 2015/16 were just below the target of 4,200. However, DTOCS continue to be higher than we would like, with capacity pressures within the domiciliary care market and the recent closure of 2 BaNES nursing homes. BaNES has already increased the domililary care provider fees to support the implementation of the National Living Wage. Recruitment is currently underway, which is seeing increased numbers coming into post. A DTOC action plan for 2016/17 will form a key part of the BCF programme in BaNES.
Permanent admissions of older people (aged 65+) to residential and nursing care homes, per 100,000 population	765	714	G	BaNES is performing well with numbers of new admissions at a significantly lower rate than 2014/15 and 15% under the target for 2015/16. This is due to sustained efforts to consider all alternative options.
Proportion of people (65+) who were still at home 91 days after discharge from hospital into reablement services	87.8%	86.6%	A	This is the percentage of people still at home in quarter 4, after being discharged in quarter 3. These are the figures reported nationally. Although slightly below target, the number of people using the service was almost 50% higher than last year and the percent still at home was a significant improvement (78.1% in 2014.15).
Proportion of high risk people case managed via Community Cluster Teams with a personalised care plan & lead accountable professional	95%	100%	G	This "local metric" was set up to ensure the new Community Cluster Teams were successfully embedded. It has been very successful, hitting 100% every quarter.

Equality, diversity and human rights

We continue to be committed to promoting equality, diversity and human rights for the people of B&NES as set out by the Equality Act 2010. The CCG recognises and values the diversity of our communities and believes that equality is pivotal to the commissioning of modern, high quality health services.

During the past year, we have worked closely with the Council's Equality and Diversity Team and continue to review our structures and processes to ensure responsibility for equality and diversity is clearly defined and Board members are competent to take a strong lead in promoting equality and diversity.

We have updated our Equality and Diversity Action Plan which highlights what we have done to meet requirements set out by the Public Sector Equality Duty (PSED)

and identifies the actions we are going to take in 2016/17 to further improve quality outcomes. Our action plan and related resources and information can be found on our website banesccg.nhs.uk/equalityand-diversity

We carry out equality analysis (equality impact assessments) as an integral part of commissioning projects. This analysis aims to identify any discriminatory or negative consequences for a particular group or sector of the community and prompts us to consider what positive actions we need to take to meet the needs of people with protected characteristics. A key example of where we have taken into account the needs of specific minority groups in 2015/16 has been as part of ***your care, your way*** which you can read about on pages xx and xx. Our joint work with the Council to support people with learning disabilities (page xx) is another example of how we strive to improve access to health services and reduce health inequalities for people with protected characteristics.
The Equality Delivery System 2 (EDS2) is a nationally available system that helps NHS organisations improve services for local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. We continue to implement EDS2 to continually review and improve our equality performance for people with protected characteristics. We carry out our EDS reviews in discussion with local partners and local people. In 2015 the Care Forum and Council Equality Team facilitated our latest EDS2 review.

We continue to use the Joint Strategic Needs Assessment (JSNA) to inform our commissioning intentions and decision making. The JSNA is a collection of research about local people, places and communities that the Council and CCG deliver in collaboration with local knowledge and community feedback. The JSNA is continually updated with live information. This meets many of the Equality and Human Rights Commission's recommendations on publishing annual equality information as the data is online, easily available, more up to date, cross referenced and more comprehensive than previously issued annual reports. We know that we need to make full use of the JSNA in our commissioning practices and all staff, including the Board, are receiving further equality and diversity training which will include information on evidence based commissioning.

Reducing health inequalities

We are committed to reducing the health inequalities that exist across B&NES. Our aim is two-fold; to reduce inequalities between communities with respect to their ability to access services and secondly to reduce inequalities between different communities with respect to the outcomes achieved for them by the provision of those services. We seek to reduce inequalities by ensuring our annual commissioning plan reflects our commitment to reducing inequalities and embedding the requirement to consider this important issue in all our individual strategies, policies and decision-making processes.

Service update: Pharmacists supporting GPs

Image – Katy Seager at care home

In 2015, BaNES CCG was praised in a report by the Royal Pharmaceutical Society for its use of sessional pharmacists in GP surgeries. These pharmacists hold approximately one session per week and their agenda mirrors the CCG's priorities of patient outcomes, patient safety and cost effectiveness of medicines. They also adapt their work to the needs of the individual practice.

Kathleen Pritchard – the sessional support pharmacist
Kathleen splits her time between Elm Hayes and the University of Bath Medical Centre.
She describes the main priorities of a practice support pharmacist as promoting the use of evidence-based prescribing choices, ensuring patient safety, monitoring high-risk drug use and reviewing cost efficiencies in prescribing.

While Kathleen is the first port of call for the practice with any drug queries, she can refer to the Medicines Management team of Prescribing Advisors at the CCG to support her when necessary. The Medicines Management team also sets out specific prescribing priorities that Kathleen focuses on. This year, much of this focus has been on the use of high-risk antibiotics and the team at Elm Hayes has significantly reduced the prescribing of Co-Amoxiclav.

Katherine Seager – the care home pharmacist
Katherine works part time with a team of five pharmacists who review medicines use among people who live in nursing and residential homes.

Reviewing what medicines a patient takes starts at the GP surgery. Katherine then compares her findings with what the care home drugs chart says for that patient to check for differences. She sees her role not as taking over the responsibility of medicines prescribing, but rather as an additional resource to help GPs prescribe the best medicines for an individual.

The CCG's Clinical Chair Ian Orpen quickly saw the benefits of a pharmacists' contribution to GP's work. Particularly their ability to keep GPs abreast of new developments and prescribing habits where patient safety can be improved and cost savings made.

"Support pharmacists give GPs the tools to have the right conversations with our patients", he added.

Improving the quality and safety of services

We want everyone to receive high quality, safe and effective care. Improving quality outcomes for our patients and service users, reducing unwarranted clinical variations and transforming healthcare through innovation are central to our plans and commissioning decisions. Throughout 2015/16 we have worked closely with neighbouring CCGs, our providers, patients, carers and other partners, to continually improve the individuals' experience and safety and improve clinical effectiveness of the services we commission. We are particularly pleased about our work with care homes, which you can read about on page 35.

CQUINs
The Commissioning for Quality and Innovation (CQUIN) payment framework allows us to reward excellence, by linking a proportion of our providers' income to the achievement of ambitious quality improvement goals and innovations. Our local CQUIN schemes for 2015/16 were in line with national priorities. Some key areas of success include:

Dementia
Across B&NES there has been improved identification of patients aged 75 years with dementia and delirium and appropriate referrals on for assessment. In addition, a number of providers have been undertaking wide reaching dementia training with staff across their organisations. For example, at the RUH, there is now dementia awareness training for relevant staff and a variety of eLearning modules are available.

Parity of Esteem to ensure that mental health is equally valued with physical health
Local providers have successfully rolled out mental health awareness training to staff in their organisations. Some providers have used the 'Brief Encounters' on-line toolkit recommended by NHS England whilst others have created their own bespoke training as part of a structured training programme. Sirona Care and Health has created a bespoke training programme and successfully delivered this to over 900 staff.

Quality Premium

The 'quality premium' rewards CCGs for improving the quality of services that they commission and for associated improvements in health outcomes and reducing inequalities.

Quality premiums paid in 2015/16 have been used to support a number of initiatives locally such as:

Hale and Hearty
The CCG commissioned this service from Age UK to support the 'frail older person' who visits their GP irregularly and does not use health or social care services. Its aim was to help people access the support they need to stay healthy and independent. Feedback on the programme has been excellent with its users reporting feeling supported and less isolated, and practices recognising the benefits of regular visits which have resulted in reducing falls, signposting to services and fewer GP appointments for social issues.

Urinary Tract Infection (UTI) Diagnosis and Treatment in Care Homes
In response to the findings from an audit of the diagnosis and treatment of UTI's in Nursing Homes in B&NES, the CCG worked in conjunction with local homes to prepare guideline resources and roll out training. All nursing home staff have received training and are engaging in an audit of practice. The project was recognised nationally and presented at the Royal Pharmaceutical Society Annual Conference in September 15 as an innovation project. It has led to the more appropriate use of antibiotics and a reduction in the potential for health acquired infections and antimicrobial resistance. No reports of unintended harm were reported, and hospital admissions for UTI, urosepsis and Acute Kidney Injury have been reduced in the nursing home population.

Antimicrobial Stewardship – Respiratory Tract Infections (RTI) in Primary Care
Reducing the inappropriate prescription and use of antibiotics is both a national and local priority, reflected in the CCG's Medicines Optimisation Strategy. The CCG established Antimicrobial Stewardship Champions within primary care with a particular focus on reducing the number of inappropriate antibiotics prescribed for upper RTI's, and promoting self-care strategies within the community. All practice pharmacists within B&NES engaged with the programme resulting in a 14 per cent reduction in antibiotic prescribing during 14/15. The programme has been carried over into 15/16 where B&NES has continued to demonstrate a reduction in the number of antibiotic items prescribed.

Quality Team case study

Improving resident experience in care homes
The project aimed to introduce a simple resident-focused way to monitor experience of care home services in B&NES.

We created a standard data collection model to help commissioners monitor care home services and supported care home owners to monitor their own services and benchmark themselves anonymously against a peer group.

The project ran for eight months from January to August 2015. 870 questionnaires were completed anonymously by residents from 16 care homes. In addition, a small survey of staff in eight care homes was carried out at the end of the study with 57

responses. The project is now complete and we are working collaboratively with a small number of care homes to see where improvements can be made.

Improving patient safety - developing the workforce
There have been a number of initiatives to support development of the local nursing workforce. One example of this collaboration between the CCG and the Council was to undertake some specialised work with care homes. This has been achieved by utilising the existing nursing forum and other events to update staff, to improve the guidance available for staff and to improve collaboration and networking.

Patient Safety Thermometer
We have introduced the Patient Safety Thermometer initiative into care homes in order to reduce avoidable patient harms for example from pressure ulcers and falls. 12 care homes signed up to the scheme during February 2015 and we provided training on how to collect and submit patient harm data. Safety Leads and Champions were established at each home to help submit data and oversee delivery of key safety initiatives in response to data findings.

We are working in collaboration with Sirona care and health, Dorothy House Hospice and care homes to develop a robust training programme for staff to improve awareness of and how to support residents whose health is deteriorating.

Quality and safety standards

We review performance against quality schedules which comprise a range of indicators including safeguarding, healthcare associated infections and patient and staff satisfaction outcomes. Performance in 2015/16 against some of these key quality indicators is shown in the table below. Often these indicators are reported at Trust level rather than CCG. Where this is the case performance for the RUH is shown.

Quality or Safety Indicator	Target	2015/16		Commentary
Number of Never Events (all CCG patients)	0	0	G	There have been no never events relating to a BaNES patient in 2015/16.
Percentage of all adult inpatients who have had a Venous Thromboembolism (VTE) risk assessment (RUH)	95%	97.8%	G	The RUH are meeting their VTE risk assessment trajectory.
WHO Surgical Safety Checklist completed for 100% of procedures (RUH)	100%	99.7%	G	This is a key indicator to improve quality and safety in surgery.
Fracture Neck of Femur - % in theatre within 36 hours (RUH)	80%	80.4%	G	The RUH has seen an improvement in this measure in 2015/16 and average performance is above the 80% target.
Healthcare acquired infection (HCAI) measure (MRSA) (All CCG patients)	0	2	R	There have been 2 cases of MRSA across the CCG. Each case is being reviewed for learning.
Healthcare acquired infection (HCAI) measure (c. difficile) (All CCG patients)	47	83	R	C. difficile has been a challenging concern in 2015/16 and this is reflected by the total number of cases reported. The CCG has been working with all healthcare organisations locally to address issues.
Healthcare acquired infection (HCAI) measure (c. difficile) Adjusted after consulation with CCG (RUH) (Post 72 hour)	22	32	R	The RUH has exceeded the national target of C. difficile infection cases. A peer review meeting took place in November 2015 with representatives from Public Health England, BaNES CCG and Wiltshire CCG and a detailed action plan has been approved by NHS England.
Mixed Sex Accommodation breaches (RUH)	0	0	G	No mixed sex accommodation breaches have been reported at the RUH in 2015/16.

Compliments, concerns and complaints

The CCG views compliments, concerns and complaints as a rich source of information and we value and act on all feedback received for services that we commission.

Responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Regulations 2009.

We continue to make sure that a concern or complaint raised by any individual is dealt with compassionately, effectively and in a timely manner.

In 2015/16, the CCG received a total of 13 complaints and 4 compliments. Most patients will feed back directly to the provider of care if they are satisfied or unhappy with their care which explains the low number received by the CCG. There have been 170 patient advice and liaison service (PALS) contacts. The following are examples of remedial actions implemented to prevent recurrence:

- The implementation of revised eligibility criteria for non-urgent patient transport services
- Additional training for Health Advisors at NHS 111
- Improved signage at the Urgent Care Centre

The CCG proactively works with staff from the provider organisations that generate complaints or concerns to ensure that service improvements, where required, are implemented. We continue to monitor performance and quality standards through regular meetings with all providers.

Contact details for submitting feedback to the CCG can be found at the end of this report.

Corporate Social Responsibility

Corporate Social Responsibility (CSR) is embedded as part of the CCG's vision and values. Aside from our shared sense of responsibility to improve the health and wellbeing for the people of B&NES, our staff have demonstrated their commitment to CSR by regular fundraising initiatives. In May 2015 our urgent care lead was part of a rescue team that responded to the devastating earthquake in Nepal. The CCG gave Dominic Morgan unpaid leave so he could travel to Nepal with the international charity Humanity First.

We recognise the importance of being careful and considered in our use of scarce resources and that we have a responsibility to ensure our decisions and actions are considerate of the local and global environment.

Estates Strategy

During the year we have worked closely with our NHS Property Services Strategic Estates Advisor to develop an Interim Estates Strategy, which we plan to finalise by the end of May 2016. We have gathered information on the buildings and sites used in B&NES to provide health services, including where these are operated directly by NHS providers, and are using this information to plan how we can make the most effective and efficient use of the space available for services in future.

Emergency planning

In collaboration with NHS England we have plans in place to deal with a major incident which includes provision for an Incident Coordination Centre and ensuring business continuity. We regularly review and make improvements to our major incident plan in line with NHS England assurance guidance. We have a programme for regularly testing our major incident plan which included a mock live scenario in December 2015 entitled 'Operation Tempest'. In the past year we have also created an area of the intranet dedicated to emergency planning information which also highlights who is on call in the event of a major incident. The Board reviews an annual self-assessment on our progress against nationally set standards for emergency and resilience planning.

Sustainability Report 2015/16:

Introduction:

Sustainability has become increasingly important as the impact of lifestyle and business choices affects the world in which we live. We recognise the impact of commissioning and procurement decisions on the carbon footprint of the NHS, and the importance of being careful and considered in our use of scarce resources.

During 2015/16 we have delivered the following objectives:

- Developing a Board approved Sustainable Development Management Plan, proportionate to our size and capacity, which sets out our vision for sustainability and our priority actions for achieving it.
- Raising Board and employee awareness of sustainability as it relates to the business of the CCG and of the contribution which everyone can make.
- Exploring opportunities to work with partners including B&NES Council, co-tenants of the St Martin's Site, and providers.
- Commencing schemes to reduce use of paper through increased use of technology and to reduce employee travel through video and tele-conferencing.
- Exploring opportunities to promote the sustainability agenda linked with implementation of plans in respect of staff health and wellbeing.
- Strengthening consideration of sustainability factors in our commissioning and procurement activities.
- Including considerations of adaptation (to the effects of climate change) in our resilience planning.

During 2016/17 our focus will be on the following objectives:

- Delivery of the action plan approved by the Board as part of the Sustainable Development Action Plan to progress our priority areas of:
    - Continuing to raise awareness
    - Further including sustainability considerations in our activities
    - Encouraging provider improvement
    - Reducing our carbon footprint
    - Promoting healthier environments
    - Further ensuring our resilience planning responds to the adaptation agenda
    - Linking our estates and sustainability strategies
- Working with our landlord, NHS Property Services, to more accurately understand our energy and water usage for our Kempthorne House head office and implement measures to reduce usage and associated carbon emissions.
- Working with other tenants of the St Martin's Hospital site on joint initiatives to reduce energy usage.

Carbon Emissions:

Using the Sustainable Development Unit modelling tool, our estimated carbon footprint for 2015/16 from all our activities including services commissioned by us is 13,683,637 tonnes of carbon dioxide equivalent emissions (tCO2 e) (2014/15 13,179,055 tCO2 e). Within this figure, 13,682,827 tCO2e are related to healthcare services commissioned by the CCG (2014/15 13,178,246 tCO2e) and a further 710

tCO2e (2014/15 638 tCO2e) was generated through procurement and contracted out business support services (for example, the Commissioning Support Unit, auditors, payroll).

Carbon footprint data for NHS organisations we commission services from will appear in their annual reports and carbon footprint data for the NHS South Central and West Commissioning Support Unit will be published as part of NHS England's annual report.

The CCG's carbon footprint is affected by the direct activities of our corporate and commissioning functions, and these areas are most easily influenced by CCG action. In 2015/16, the CCG as a corporate body produced 100.38 tCO2 e compared to 170.75 tCO2 e in 2014/15 – a reduction of 41.21%. It should be noted that some of this reduction is attributable to changes in methodology recommended by the NHS Sustainable Development Unit.

The specific impact of these is identified by area. The table below shows the changes between years:

CO2 Emissions (tonnes of CO2e)	2015/16	2014/15	Change in tCO2 e	% change
Paper products	2.86	15.60	-12.74	-81.66%
Other manufactured products	2.88	7.03	-4.15	-59.08%
Information and communication technologies	12.10	25.70	-13.60	-52.91%
Freight transport	0.84	0.00	0.84	N/A
Food and catering	1.40	11.37	-9.97	-87.65%
Construction	0.03	1.10	-1.07	-97.41%
Water and sanitation	0.28	0.63	-0.35	-55.56%
Waste products and recycling	1.62	1.62	0.00	-5.56%
Travel	10.86	37.14	-26.28	-70.76%
Electricity	37.18	39.43	-2.25	-5.71%
Gas	30.33	31.13	-0.80	-2.57%
Total	**100.38**	**170.75**	**-70.37**	**-41.21%**

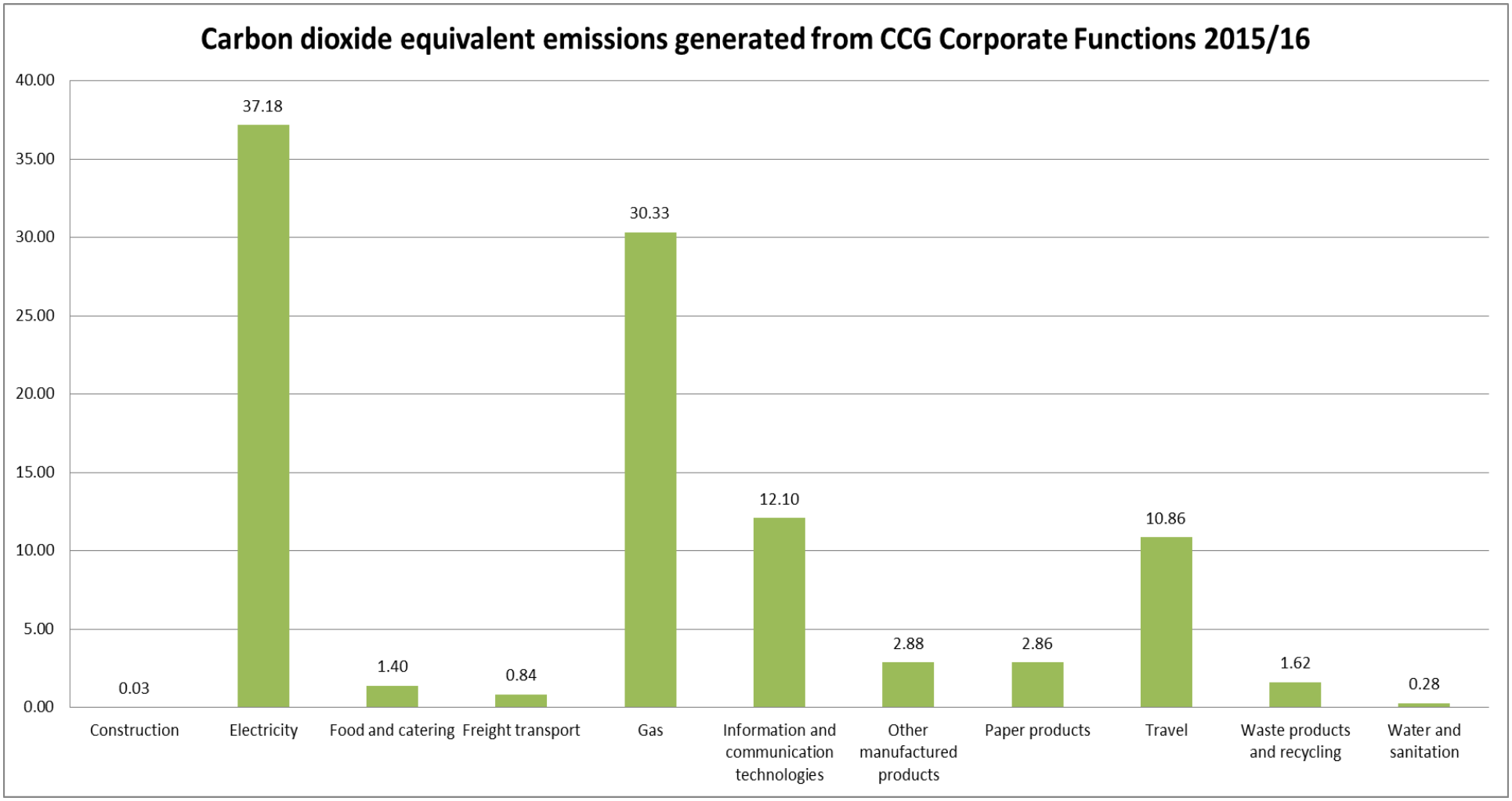
The reductions in emissions related to paper products, other manufactured products, ICT, food and catering are all as a result of decreased expenditure on these areas by the CCG between the two financial years.

Whilst there has been a significant reduction in the carbon emissions associated with staff travel, there has been a change in guidance on this area. In 2014/15 the figures included carbon associated with staff commutes to work, whereas 2015/16 is based only on actual business mileage which is reimbursed by the CCG as employer, e.g. travel to meetings. On a like for like basis, carbon associated with travel in 2014/15 would be restated at 25.40 tCO2 e, resulting in a reduction of 14.54 tCO2 e between years or -57.24%. This is a result of initiatives by the CCG to encourage reduced

travel through making use of technology rather than attending external meetings face-to-face.

Further details regarding energy, water and waste are shown below.

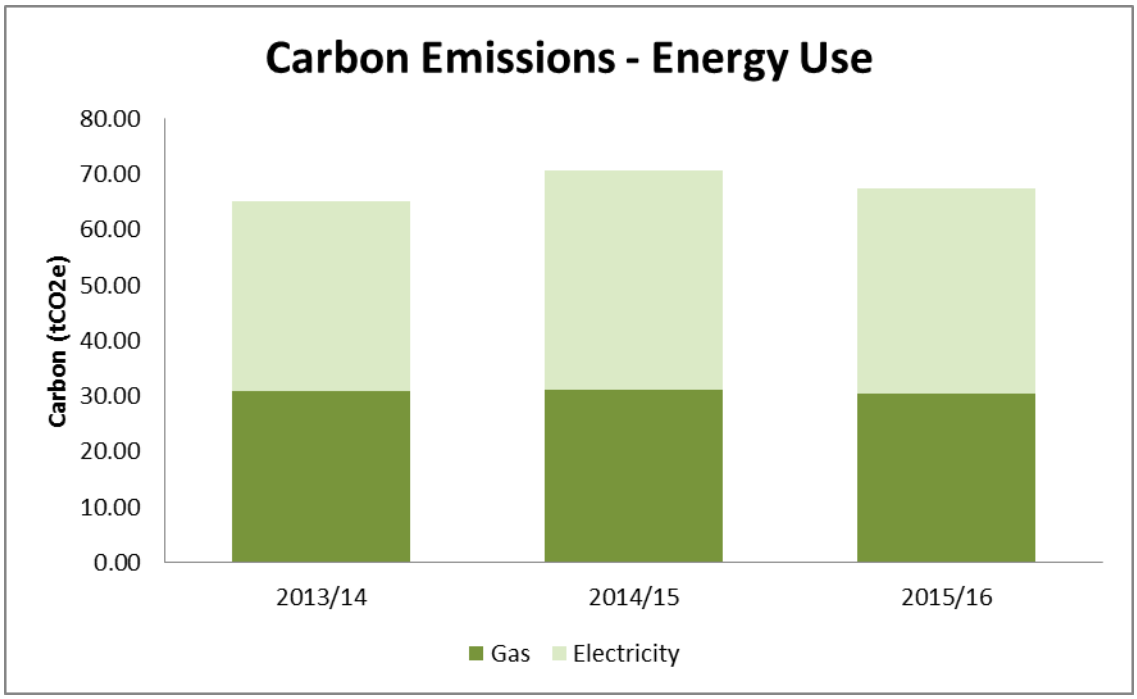
The chart below illustrates the carbon impact of our actions as a corporate body during 2015/16.


Carbon dioxide equivalent emissions generated from CCG Corporate Functions 2015/16
40.00
35.00
30.00
25.00
20.00
15.00
10.00
5.00
0.00
0.03
37.18
1.40
0.84
30.33
12.10
2.88
2.86
10.86
1.62
0.28
Construction
Electricity
Food and catering
Freight transport
Gas
Information and communication technologies
Other manufactured products
Paper products
Travel
Waste products and recycling
Water and sanitation

Energy:

The table below and following chart show our expenditure on energy for 2015/16 as compared to the previous two years, and the resulting modelled carbon emission impact. Although the data is based on apportioned usage across the St Martin's Hospital site, the CCG has demonstrated a reduction in consumption of gas in year although there has been a small increase in electricity consumption. Overall, the carbon emissions associated with the CCG's energy usage are lower in 2015/16 than in 2014/15 by approximately 5%.

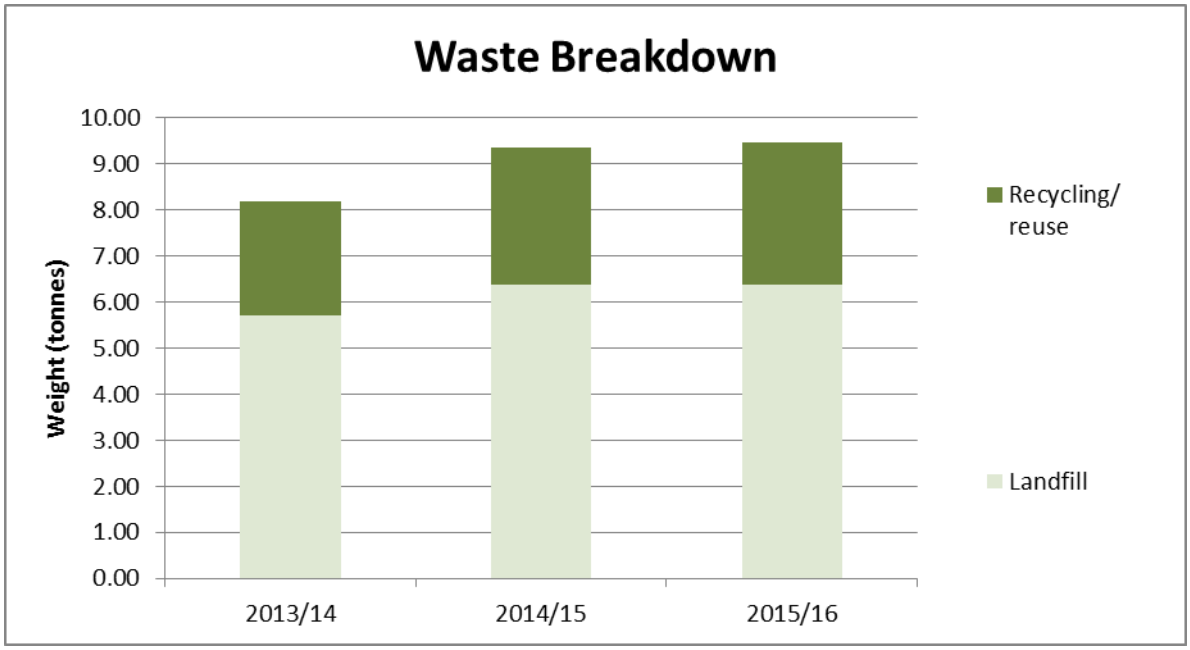
Resource		2013/14	2014/15	2015/16
Gas	Use (kWh)	145,782	148,388	144,586
	tCO_2e	30.93	31.13	30.33
Electricity	Use (kWh)	60,941	63,664	64,673
	tCO_2e	34.12	39.43	37.18
Total Energy CO_2e		65.05	70.56	67.52
Total Energy Spend		£ 12,444	£ 11,663	£ 10,103



Waste:

The table below and following chart show the volume of waste arising from our activities and the resulting modelled carbon emissions impact. Although the volume of waste generated has increased slightly (primarily due to an increase in staff numbers including bringing in-house a number of services previously provided by the Commissioning Support Unit in October 2014), we have also delivered a small increase in the percentage which we succeed in recycling or reusing for the second consecutive year:

Waste		2013/14	2014/15	*2015/16*
Recycling/ reuse	(tonnes)	2.48	2.96	3.08
	tCO_2e	0.04	0.06	0.06
Landfill	(tonnes)	5.71	6.38	6.38
	tCO_2e	1.40	1.56	1.56
Total Waste (tonnes)		8.19	9.34	9.46
% Recycled or Re-used		30.28%	31.69%	32.54%
Total Waste tCO_2e		**1.44**	**1.62**	**1.62**



Water:
The table below shows our expenditure on water and sewerage during 2015/16 as compared to the previous two years. As with energy, the data is based on apportioned usage across the St Martin's Hospital site. We have demonstrated significantly decreased water consumption between 2014/15 and 2015/16. This is partially attributable to resolution of water leakage problems experienced during 2014/15.

Water		2013/14	2014/15	2015/16
Mains	m^3	447	695	306
	tCO_2e	0.41	0.63	0.28
Water & Sewage Spend		**£ 1,740**	**£ 2,737**	**£ 1,103**

Commissioning:
As commissioners, our most significant impact is through the services we commission, which we can influence through both contractual mechanisms and partnership approaches. We have reviewed the sustainability information for those NHS providers from whom we commission the highest volume of services, which disappointingly presents a more mixed picture than in 2014/15. Whilst South West Ambulance Services NHS FT have achieved an Excellent Sustainable Development reporting score, and the Royal United Hospital and University Hospitals Bristol have achieved Good scores, others are Poor or unreported. Most organisations have in place a Sustainable Development Management Plan and there are examples of good practice in individual organisations.
We are looking at ways of increasing our engagement with providers on this important issue.

Financial review

The CCG has achieved its statutory financial duties reflecting the strong financial management within the organisation.

We closed the year with a total resource limit budget of £227.043m and operated within our revenue resource budget for 2015/16, achieving our target surplus of £2.247m.

Savings schemes of £4.016m had been planned in 2015/16, of which £3.344m were delivered in the year. The savings delivered included new schemes which had been initiated in year. The resources released were used to fund a range of investments during 2015/16 to support the CCG strategy.

The recurrent administration resource budget of £4.178m was underspent by £0.452m. The primary reason for this under-spend was a number of vacancies

during the year. The CCG delivered the requirement to reduce administration budgets by 10 per cent from 2014/15 to 2015/16.

More detail on our performance against statutory financial targets and duties is provided below:

Operational Financial Balance – Revenue Resource Limit, including Administration Costs

We are required to operate within our allocated Revenue Resource Limit and achieved this by delivering a surplus of £2.247m.

	2015/16	2014/15
	£000	£000
Performance for the year ended 31 March 2016:		
Total Net Operating Cost for the Financial Year	**224,796**	216,173
Revenue Resource Limit	**227,043**	219,858
Underspend Against Revenue Resource Limit	**2,247**	3,685

Administration costs

Administration costs are defined as 'any cost incurred that is not a direct payment for the provision of healthcare or healthcare related services'. Such costs include CCG pay costs, charges for corporate and support services outsourced to a Commissioning Support Unit, NHS Property Services occupancy charges and Other Non-Pay costs relating to the running of the CCG.

The CCG is required to manage expenditure on administration costs within the nationally set allocation.

As well as the initial administration allocation of £4.178m, the CCG received a non-recurrent allocation for the Quality Premium of £0.529m. NHS England notified CCGs that Quality Premium funding must be recorded as administration costs to match the accounting treatment in the Department of Health accounts. However, costs incurred by the CCG are reported in programme costs in line with the nature of expenditure incurred. The CCG spent the allocation in total in accordance with the purposes of the Quality Premium.

Recurrent administration costs

	2015/16	2014/15
	£000	£000
Performance for the year ended 31 March 2016:		
Administration Cost for the Financial Year	**3,726**	4,026
Administration allocation	**4,178**	4,655
Underspend Against Allocation	**452**	629

Non recurrent administration costs – Quality Premium allocation

	2015/16	**2014/15**
	£000	**£000**
Performance for the year ended 31 March 2016:		
Administration Cost for the Financial Year	**0**	**7**
Administration allocation	**529**	**350**
Underspend Against Allocation	**529**	**343**
Quality Premium expenditure within Programme Costs	**572**	**367**
Overspend on Quality Premium	**43**	**24**

Better Payment Practice Code – Measure of Compliance

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt, whichever is later.

Compliance is measured as at least 95 per cent of invoices paid within 30 days or within agreed contract terms.

The table below demonstrates the CCG's compliance in all areas measured.

	2015/16	**2015/16**	2014/15	2014/15
	Number	**£000**	Number	£000
Non-NHS Creditors				
Total bills paid in the year	**3,928**	**86,334**	2,917	50,060
Total bills paid within target	**3,741**	**85,029**	2,773	49,213

Percentage of bills paid within target	**95.24%**	**98.49%**	95.06%	98.31%

NHS Creditors

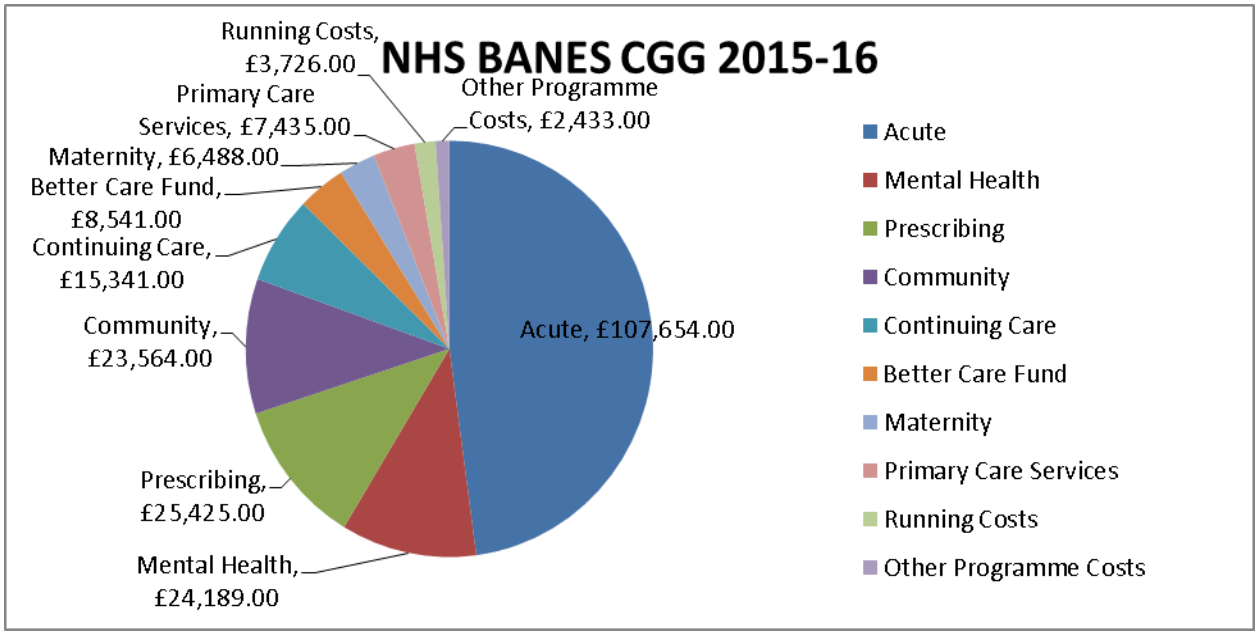
Total bills paid in the year	**2,486**	**116,828**	2,314	123,270
Total bills paid within target	**2,406**	**114,878**	2,261	121,874
Percentage of bills paid within target	**96.78%**	**98.33%**	97.71%	98.87%

Cash position

Our financial statements show cash held of £197k as at 31 March 2016. The CCG was required to have a balance no greater than 1.25 per cent of the cash value drawn down in March, which equates to £206k and therefore the CCG has successfully met this target.

CCG expenditure by areas of care

We spend money on a range of healthcare services commissioned for the people of B&NES. The chart below (to follow) shows the types of services provided and illustrates how much we spent on each during 2015/16. Acute healthcare makes up the highest percentage of expenditure (52 per cent) by a considerable margin, with the next largest areas of expenditure being Prescribing, Mental Health (including Learning Disability) and Community Services which are all similar in value.



In line with the CCG strategy, we envisage a shift in the percentage spent from Acute Healthcare to Primary Care and Community Care as pathways are redeveloped and services reviewed.

Future Financial Position

The Board has approved a budget for 2016/17 which plans to deliver a surplus of £2.298m. Planned net savings of £8,780m are required to offset increasing costs and activity pressures and to support priority investments. This is in line with our 5 Year Strategic Plan.

Financial Statements

Full detail on the financial performance for the year is provided in the Annual Accounts, which have been prepared under a Direction issued by NHS England under the NHS Act 2006 (as amended) and include explanatory notes, Accountable Officer statements, and the External Auditor's opinion. These form the final section of this Annual Report.

Signed : **Date**

Sarah James
Deputy Accountable Officer
Signed for and on behalf of Accountable Officer

Section 2: Accountability Report

Members' Report

The following table includes details of the 27 GP practices that comprise the membership of BaNES CCG.

Practice Name	Practice Name
Batheaston Medical Centre	**Harptree Surgery**
Combe Down Surgery	**St Augustine's Surgery**
Fairfield Park Health Centre	**Temple House Surgery**
Grosvenor Medical Centre	**West View Surgery**
Newbridge Surgery	**Elm Hayes Surgery**
No 18 Upper Oldfield Surgery	**Hillcrest Surgery**
Oldfield Surgery	**Hope House Surgery**
Pulteney Street Surgery	**St Chad's Surgery**
Monmouth Surgery	**Somerton House Surgery**
Catherine Cottage	**St Mary's Surgery**
St James's Surgery	**Westfield Surgery**
St Michael's Surgery	**Widcombe Surgery**
Rush Hill & Weston Surgery	**Bath University Medical Centre**
	Chew Medical Centre

Chair and Chief Officer (Accountable Officer)

The Clinical Chair of the CCG from 1 April 2015, throughout the year and up to the signing of the Annual Report and Accounts was Dr Ian Orpen.

The Chief Officer (Accountable Officer) from 1 April 2015, throughout the year and up to the signing of the Annual Report and Accounts was Tracey Cox.

Our Board

The membership of our Board during 2015/16 is set out in the table below:

Board Members (voting)	
Dr Ian Orpen	Clinical Chair
John Holden	Lay Member (audit and governance) / Vice Chair
Tracey Cox	Chief Officer
Dr Ruth Grabham	Medical Director
Dr James Hampton	GP
Dr Elizabeth Hersch	GP
Dr Shanil Mantri ***From April 2015 to February 2016***	GP
Dr Jonathan Osborn ***From March 2016 to April 2016***	GP
Dr Daisy Curling	Sessional GP
Helen Harris	Practice Manager
Suzannah Power	Lay Member (patient and public involvement)
Myles Taylor	Secondary Care Specialist Consultant
Dawn Clarke	Director of Nursing & Quality / Registered Nurse
Sarah James	Chief Financial Officer

Profiles of our Board Members

Clinical Chair

Dr Ian Orpen Clinical Chair	I moved to Bath in 1986 and after working at the RUH for several years became a GP in Bath in 1989 and a partner at St James's Surgery in 1991. I worked as a GP Specialist in Orthopaedics from 1996 to 2011 and was a GP Trainer for 12 years. I was the lead for clinical trials in the practice for 20 years and was Chair of BARONET (Bath Area Research Organisation Network) from 2004 till 2011. I spent two years on the Clinical Management Board of Assura Minerva LLP, who amongst other things ran a GP-led Walk in Centre in Bath. I was a school governor at Bathampton Primary School from 2000 to 2008 and Chair of Governors from 2005/7. I became Chair of the shadow CCG in 2010 following an election by local GPs. I took up the formal position as CCG Chair on authorisation in 2013.
Appointed to the Board April 2013	
Other roles Chair of CCG Board Member of Remuneration Committee Co-Chair of B&NES Health & Wellbeing Board Chair of System Resilience Group Member of the Academic Health	

Science Network Board RUH Council of Governors Stakeholder member B&NES Public Services Board member LGA Health and Wellbeing Peer Reviewer West of England Genomics Partnership Board Member	I am driven by a desire to see the services for the local population develop in a dynamic way, which meets their more complex needs within existing financial constraints. I recognise the value in developing and maintaining good relationships the partners we work alongside. In particular, I am keen to see closer working with the Council. I am Clinical Lead at the CCG for Prevention and Self Care

Chief Officer

Tracey Cox Chief Officer Appointed to the Board April 2013 Other roles Chair of Joint Commissioning Committee Chair of Transformation Group Chair of Executive Team Member of System Resilience Group	I joined the health service in 1990 as a management trainee after graduating from Goldsmith's College, University of London. I worked in several London hospitals managing different specialties prior to moving to Bath in 1997. I moved to Bath in 1997 and worked at the RUH until 2001. I then began my commissioning career with B&NES Primary Care Trust and transferred to the CCG in April 2013. I have a long history and understanding of the local area and remain committed to developing high quality services for local people that are amongst the best in the country. I believe strongly in developing partnerships and relationships across the health and care system and have a particular interest in organisational development.

Executive Members

Dr Ruth Grabham Medical Director Appointed to the Board April 2013 Other roles Member of Joint Commissioning Committee Member of Quality Committee Member of the Joint Primary Care Co-Commissioning Committee Member of Clinical Commissioning Reference Board	I qualified from Charing Cross Hospital Medical School in London in 1987 and became a partner at Newbridge Surgery in Bath in 1993. In the last 25 years I have very much enjoyed looking after my patients, and the continuity and variety that general practice offers. I have also helped to set up and chair our original out of hours service and worked as a cardiology clinical assistant at the RUH. Since September 2010, I have been fortunate to be able to use that experience in working for our CCG, and have seen the real benefits to patients, that clinicians working in developing services has made. I am currently the clinical lead for the redesign of our diabetes services and for primary care.

Sarah James Chief Financial Officer Appointed to the Board April 2013 Other roles: Member of the Joint Commissioning Committee Member of System Resilience Group Member of the Joint Committee for the Oversight of Joint Working Member of the Joint Primary Care Co-Commissioning Committee Chair of the Information Governance Steering Group Member of the IM&T Steering Group HFMA South West Branch	I joined the NHS in 1987 as a finance trainee after graduating from the University of Surrey and qualified as a Chartered Public Finance Accountant in 1993. I have since worked in a number of NHS provider and commissioner organisations in B&NES and the South West, joining B&NES Primary Care Trust in 2009. I have worked with the CCG since it was set up in shadow form in April 2012. I believe that the strength of GP involvement in commissioning locally and the unique way in which we work with the Council provides a really sound basis for the CCG to tackle the challenges it faces.

Treasurer HFMA Commissioning Finance Faculty Steering Group member	

Dawn Clarke Director of Nursing & Quality and Registered Nurse Board Member Appointed to the Board April 2013 Other roles: Chair of the Exceptional Funding Panel Member of the Quality Committee Member of Joint Commissioning Committee Member of System Resilience Group Various roles on safeguarding Board, and other regional groups.	I qualified as a registered nurse from the University Hospital of Wales in 1984 and have held a range of roles in the NHS, including Infection Control Nurse, Clinical Governance lead, Primary Care and Performance Lead and, until 2013, as Assistant Director of Patient Safety and Clinical Quality. I am passionate about improving patient safety and quality of care and enjoy working to reduce unwarranted clinical variation and improve standards. I do not underestimate the challenge for the CCG in commissioning high quality safe and effective services for local residents. I am delighted to be working with the wider health and care system to deliver the Sustainability and Transformation Plan (STP) in 2016 and beyond.

Practice Representatives on the Board

Dr James Hampton GP Representative Appointed to the Board April 2013 Other roles: GP Cluster Commissioning Lead Board Member (Bath Central), Member Joint Commissioning Committee Member of the Individual Patient	I qualified from Charing Cross Hospital Medical School in 1980 and have been a GP in Twerton and Southdown since 1990. My clinical interests include orthopaedics and sport medicine, and I also cover Bath Rugby as one of the pitch-side doctors. I believe that the establishment of the CCG puts clinicians back at the heart of developing services for patients, and gives us the best chance of maintaining quality NHS services locally, using the resources we have available. I am Clinical Lead at the CCG for Musculoskeletal (MSK)

Panel.	

Dr Elizabeth Hersch GP Representative	I graduated from Bristol University in 1993 and completed my GP training in 1997. I have been a GP Principal at St Chads Surgery, Midsomer Norton, since 2001. My clinical interests include women's health, dermatology and clinical governance. I am an active member of the medicines management group and safeguarding leads group. In the past year I have set up a local urgent care clinical group that reports to the system resilience group. This year we will focus on the falls pathway. I am cluster lead and chair for the Norton - Radstock local cluster group and am a Board member for the CCG. I am Clinical Lead at the CCG for urgent care, end of life care and maternity care.
Appointed to the Board April 2013 and re-appointed in April 2015	
Other roles: Member of the Joint Commissioning Committee (JCC) NHS 111 Clinical Governance Lead Member of the System Resilience Group	

Dr Shanil Mantri GP Representative	I qualified from Kings College London in 2001 and finished my GP training in 2009 after spending two years working in the RUH and a year at St James's Surgery, Bath. Having spent five years working as a freelance/sessional GP in the Bath and Wiltshire area, I became a partner at Newbridge Surgery, Bath. Whilst on the CCG Board, I was clinical lead for Information Management & Technology (IM&T) which included leading the interoperability programme. I was cluster lead for Chew – Keynsham cluster group.
Appointed to the Board April 2013 – February 2016	
Other roles: Member of the Joint Commissioning Committee Chair of the CCG for Information Management & Technology (IM&T) steering group Chief Clinical Information Officer of CCG Clinical Lead for Children's Services	

Chair of the Interoperability Board	

Dr Daisy Curling GP Representative	I work as a salaried GP at Fairfield Park Health Centre in Bath for 4 sessions a week and spend 1 day a week working for the CCG.
Appointed to the Board October 2014	
Other roles: Member of Joint Commissioning Committee Member of Quality Committee	I am Chair of the local sessional GP group "Sulisdoc" and I represent sessional GP views on the CCG Board. I am Clinical Lead at the CCG for Mental Health, medicines management, learning disabilities and dementia, paediatrics I am the CCG GP cluster lead for the Bath Aqua Cluster

Dr Jonathan Osborn GP Representative	I moved to Bath in 2014 when my wife took up a post as a Consultant Respiratory Physician at the RUH. I was previously a GP partner at College Surgery in Cullompton where I was also founding Medical Director of Devon Health Ltd. I am currently working as a sessional GP at Combe Down Surgery. I have a medical MBA from the University of Massachusetts (Amherst) and a research MSc from University of Oxford. I am a Member of the Royal Colleges of GPs and Surgeons, a Fellow of the Institute of Directors, and a Chartered Director. I have a particular interest in corporate governance, risk and strategy. I am Clinical Lead at the CCG for Interoperability. I am cluster lead for Chew – Keynsham cluster group.
Appointed to the Board March 2016	
Other roles: Member of the Joint Commissioning Committee	

Helen Harris Practice Manager	I have worked for the NHS since 1997, and have been

Representative Appointed to the Board June 2013 Other roles: Member of Joint Commissioning Committee Member of Joint Primary Care Co-commissioning committee. Member of B&NES Interoperability Board Member of IM&T Steering Group	Practice Manager at Number 18 Surgery, in Bath since 2001, representing B&NES practice managers on a number of committees. Prior to this I worked in retail management for a very customer-focused company. I feel that patient engagement, communication and involvement are key to commissioning good patient services and care for the local community. Since joining the Board in 2013, my role has developed, particularly with the CCG taking on co-commissioning of primary care and within this, I support interoperability and primary care. I am cluster lead for Bath Sulis group of GPs.

Independent Members (voting members)

Lay members are key appointments for the CCG, bringing different perspectives to the organisation, drawn from different professions, roles, background and experience. These differing insights into the range of challenges and opportunities facing the CCG ensure that it can take a balanced view across the whole of its business.

The role of the Independent Member is to:

- Ensure the Board and the wider CCG acts in the best interests with regard to the health of the local population at all times
- Ensure the interests of patients and the community remain at the heart of discussions and decisions
- Ensure the Board and the wider CCG behaves with the utmost probity at all times
- Bring an independent view of the work of the CCG that is removed from the day to day running of the organisation.

John Holden Lay Member (audit and governance) & Vice Chair Appointed to the Board April 2013	I studied at Emmanuel College, Cambridge, then went on to a 26-year career with BP. After time as the Development Director of the Electricity Pool, I enjoyed two terms as CEO of Companies House and Registrar of Companies. During

	Other roles: Chair of the Audit Committee Chair of the Remuneration Committee Member of the Joint Primary Care Co-Commissioning Committee Member of the Quality Committee	this period, I was also the Registrar of Political Parties. I have held non-executive director appointments with, and been alternate chair of audit in, the Passport Agency, the Criminal Records Bureau and the Independent Police Complaints Commission. I was a non-executive director with Wiltshire Primary Care Trust on formation in 2006 and chaired their Audit Committee. I continued with NHS B&NES and Wiltshire until 2013 when I succeeded to my present CCG role. I am focused on helping secure the best possible healthcare for our local population and the best possible value for money for the taxpayer. The need for that twin focus has never been greater and the challenges to achieving it have rarely been tougher.

	Suzannah Power Lay Member **(**patient and public involvement) Appointed to the Board February 2014 Other roles: Chair of the Quality Committee Chair of the Joint Primary Care Co-Commissioning Committee Chair of Your Health, Your Voice Public Engagement Group Member of the Audit Committee Member of the Remuneration Committee	I have worked in a range of customer-focused roles in the private, public and voluntary sector. For many years I served as patient representative on the British Heart Foundation Council, and alongside that I worked with clinical and lay colleagues on the development of several NICE guidelines, including Patient Experience in Adult NHS Services. From 2011 to 2015 I reviewed academic research proposals and served as a member of the Research for Patient Benefit South West Region Funding Committee. My interest in research continues through ongoing involvement with a project at the University of Birmingham Centre for Cardiovascular Sciences.

	Myles Taylor Independent Secondary Care Consultant	After qualifying in medicine at Worcester College, Oxford, my career path has taken me to Bristol, Norwich and Cambridge before moving to Queen Charlotte's & Chelsea Hospital (QCCH). At QCCH, my research into monochorionic twins and also non-invasive fetal ECG resulted in me obtaining a PhD. I also completed sub-speciality training at the Centre for Fetal Care before completing my general training. I was appointed as a Consultant Obstetrician and Gynaecologist at the Royal Devon and Exeter Foundation NHS Trust in 2003. Whilst being a subspecialist in fetal medicine and having a busy obstetric practice with regular sessions on delivery suite, I also have a full general gynaecological practice with a special interest in urogynaecology.
	Appointed to the Board June 2014	
	Other roles	

Associate Lay Member

This is a new post for the CCG in 2015/16 and although Katie Hall is not a member of the Board this role provides strategic and impartial support to two key committees of the CCG's Board.

	Katie Hall Associate Lay Member	I am a policy and communications specialist based in Bath. I am an Associate on the Local Government Association's (LGA) Care and Health Improvement Programme. I was Chair and Vice-Chair of the LGA Community Wellbeing Board 2013-2015. A former Councillor on Bath and North East Somerset Council, I have held the portfolio of Cabinet Member for Community Integration and served on the Health and Wellbeing Board. I am a governor of the 'outstanding' Three Ways School in Bath. Originally from County Durham, I studied chemistry at the University of Leeds before working in Brussels, London and Amsterdam.
	Appointed to the Board February 2016	
	Other roles: Member of the Audit Committee Member of the Joint Primary Care Co-commissioning Committee	

Board committees

Throughout 2015/16 the Board has had five sub-committees:-

- Audit Committee
- Quality Committee
- Remuneration Committee
- Joint Commissioning Committee (CCG and Council membership to support integrated working).

- Joint Primary Care Co-Commissioning Committee; nearly created in July 2015 to jointly commission primary medical services with NHS England for the people of B&NES.

The membership of the Audit Committee during 2015/16 comprised:-

Audit Committee Members and those in regular attendance	
Members	
John Holden	Committee Chair and Lay Member (audit and governance) **Committee Member**
Suzannah Power	Lay Member (patient and public involvement) **Committee Member**
Katie Hall	Associate Lay Member **Committee Member**
In Attendance	
Tracey Cox	Chief Officer
Sarah James	Chief Financial Officer
Dawn Clarke	Director of Nursing & Quality
External Audit Representative	Grant Thornton
Internal Audit Representative	KPMG
Counter Fraud and Security Management specialists	Secure

Other Board Sub-Committees
For details on our Remuneration Committee please refer to the Remuneration Report section and all other committees of the Board, in the Governance Statement Section.

Statement of Disclosure to Auditors
Each individual who is a member of the Board, at the time the Members' Report is approved, confirms:

- So far as the member is aware, that there is no relevant audit information of which the CCG's external auditor is unaware; and
- The member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the CCG's auditor is aware of that information.

Declarations of Interest
As part of the CCG's procedures in place to deal with situations where a director/member has a conflict of interest, a Register of Interest is maintained and published on the CCG's website.

Personal Data Related Incident

The CCG had one breach of data security during 2015/16. This lapse of data security was reported immediately to the Information Commissioner and has been confirmed as being at severity 0 (minor breach). The Information Commissioner was satisfied with actions taken by the CCG.

Statement of accounting officer 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 Tracey Cox 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 himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

- That the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable

Signed : **Date**

Sarah James
Deputy Accountable Officer
Signed for and on behalf of Accountable Officer

Annual governance statement

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 CCG 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 the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing on best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice. BaNES CCG demonstrates this through the following key main principles of the Code:-

1. Leadership

The CCG is headed by an effective Board with a Chair and the full complement of all positions on the Board. Board meetings are held every other month in public to consider agenda items and make decisions. Members of the public attend and have the opportunity to ask questions and raise issues with the Chair and the Board members. There is a clear responsibility between the head of the CCG (the Chair of the Board) who is responsible for the strategic management of the CCG and the Accountable Officer who is responsible for the operational management of the business. The Chair of the CCG is separate from the Accountable Officer. The role of the Board is set out in our Constitution which details: mission, values and aims; functions and general duties; decision making structures; roles and responsibilities; standards of business conduct; transparency, ways of working and standing orders.

2. Effectiveness

The CCG's Board and its committees are made up of elected clinicians, appointed clinicians and lay members with appropriate skills and knowledge

required for the performance of their duties and responsibilities effectively. Profiles of all Board members can be found on pages 51-56.

A formal process for appointments is in place and adhered to with new appointments provided with a range of strategic information covering quality, finance, performance, strategy, policy and risk which is subject to annual evaluation. In addition the organisation learns and improves its performance through continuous monitoring and review of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

3. Accountability

There are clear accountability arrangements in place throughout the organisation. There are processes in place for effective management of 'conflicts of interest' and a robust process for risk management and internal control through regular reporting and interaction with internal and external audit. The Board ensures that there are proper and independent assurances given on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes.

4. **Remuneration**

This is set by the Remuneration Committee. The committee is a sub-committee of the Board and advises on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the organisation. Drawing on benchmarking and expert HR advice, the Remuneration Committee has advised the Board on appropriate remuneration and contractual arrangements for Board members and others not covered by Agenda for Change terms and conditions.

5. Relations with shareholders

The CCG holds regular meetings and briefing sessions for the membership through its Council of Members, Cluster meetings and GP Forums. Engagement with the public and other stakeholders also takes place through patients groups, partners and the local authority. There are partnership arrangements with the local strategic partnership and also the local Health and Wellbeing Board. There are a range of other partnerships relevant to stakeholder groups including Patient Participation Groups (PPGs), the Local Safeguarding Boards, collaborative arrangements and meetings with NHS England and Local Council both to provide assurance and as a co-commissioner. Arrangements are in place to effectively share information between partners. We achieve a dialogue with our shareholders based on the mutual understanding of our objectives by engaging our stakeholders in our strategic planning rounds and in specific clinical leadership events.

Further work has been carried out in terms of drawing on best practice through a gap analysis against the suggested achievement criteria in the NHS Code of Governance for CCGs, as detailed on page 70.

The CCG governance framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states: *"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."*

The CCG Constitution is constructed around the exemplar model constitution provided by NHS England. The agreed amendments made from the exemplar model primarily reflected the landscape of the membership practices within B&NES and the final committee structure adopted by the CCG. During 2015/16 the Constitution was subject to further amendment following engagement and consultation with member practices. These further changes included:-

- Updating the member practice cluster re-configuration
- Reflecting some minor changes to the Board sub-committees' terms of reference, with the notable exception of our Audit Committee which has taken on the new additional responsibility of the role of Auditor Panel to oversee the selection of the External Auditor to meet new statutory guidelines
- Introduced a new committee for joint commissioning of primary care with NHS England.

These changes further strengthen the Constitution and governance structures for the organisation. The Constitution includes the 'Scheme of Reservation and Delegation' and outlines those matters that are reserved for the membership as a whole and those that are the responsibilities of the Board. The CCG's Constitution is published on our website and can be found at:
http://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/constitution
We work as an organisation that is clinically-led and situated close to patients and our communities.

CCGs are membership organisations, accountable to our GP practices meaning that the decisions made should reflect the views of those involved.

The diagram below demonstrates membership:

Figure 1 : BaNES CCG Member Organisation Structure Chart

BaNES CCG Board	
6 voting non-clinicians	8 voting clinicians
1 Patient/Public Adviser (Lay)	1 Clinical Chair (GP)
1 Vice Chair / Audit & Governance Advisor (Lay)	1 Medical Director (GP)
1 Chief Officer	3 GP Cluster Leads
1 Chief Financial Officer	1 Sessional GP Cluster Lead
1 Practice Manager, Cluster Lead	1 Secondary Care Clinician
	1 Registered Nurse

CCG members

Our member practices play a role to achieve the best possible health outcomes for their practice population and through their contribution to the work of the CCG, for the population of B&NES as a whole. The CCG is a membership organisation made up of 27 GP practices in B&NES, within four clusters. Each practice in BaNES CCG elects a GP to sit on our **Council of Members**. This group meets twice a year and is responsible for:

- representing the interests of local GPs
- approving the CCG's Constitution and proposed changes to the Constitution
- nominating for appointment of Board members
- holding the Board members, both individually and collectively, to account for their performance
- informing the CCG's commissioning plans
- agreeing initiatives to improve the quality and outcomes of patient care and better use of resources.

Figure 2 BaNES CCG GP Practices within Clusters

Norton Radstock Cluster	Chew & Keynsham Cluster
Elm Hayes Surgery	Chew Medical Practice
Hillcrest Surgery	Cameley Surgery
Hope House Surgery	Harptree Surgery
Somerton House Surgery	St Augustines Medical Practice
St Chads Surgery	Saltford Surgery
Chilcompton Surgery	Temple House Practice
St Mary's Surgery	West View Surgery
Westfield Surgery	

Bath Sulis Cluster	Bath Aqua Cluster
Catherine Cottage Surgery	Batheaston Medical Centre
Combe Down Surgery	Fairfield Park Health Centre
Grosvenor Place Surgery	Oldfield Surgery
Monmouth Surgery	Pulteney Pratice
Newbridge Surgery	University Medical Centre
Number 18 Surgery	Widcombe Surgery
Rush Hill Surgery	
Weston Surgery	
St James' Surgery	
St Michaels Surgery	

Council of Members performance & effectiveness

The Council of Members is chaired by the Clinical Chair of the CCG. In 2015/16 the Council of Members met on two occasions and held two ballots as follows:-

Meetings/Votes		
Date	**Item**	**Action**
Meeting - 19 May 2015	Presentation of Annual Report & Accounts 2014/15	Delegated authority for the CCG Board to approve on recommendation of the Audit Committee
Electronic Vote - September 2015	Vote : Proposed new models for Bath Clusters	Option B approved as shown in fig 2.
Electronic Vote - January 2016	Vote : Election of GP Board representative	Dr Jonathan Osborn successfully elected
Meeting - 10 March 2016	Presentation of Operational Plan 2016/17	Approved to delegate final approval of Operational Plan detail to CCG Board

	Amendments to the CCG's Constitution	Approved amendments to the CCG's Constitution

Attendance at meetings during 2015/16 was in the range of 98-100 per cent.

Our Board

Our CCG is led by the Board which consists of a mixture of GP representatives, members of the CCG executive team, other clinicians and lay representatives, as outlined earlier in the Members' Report.

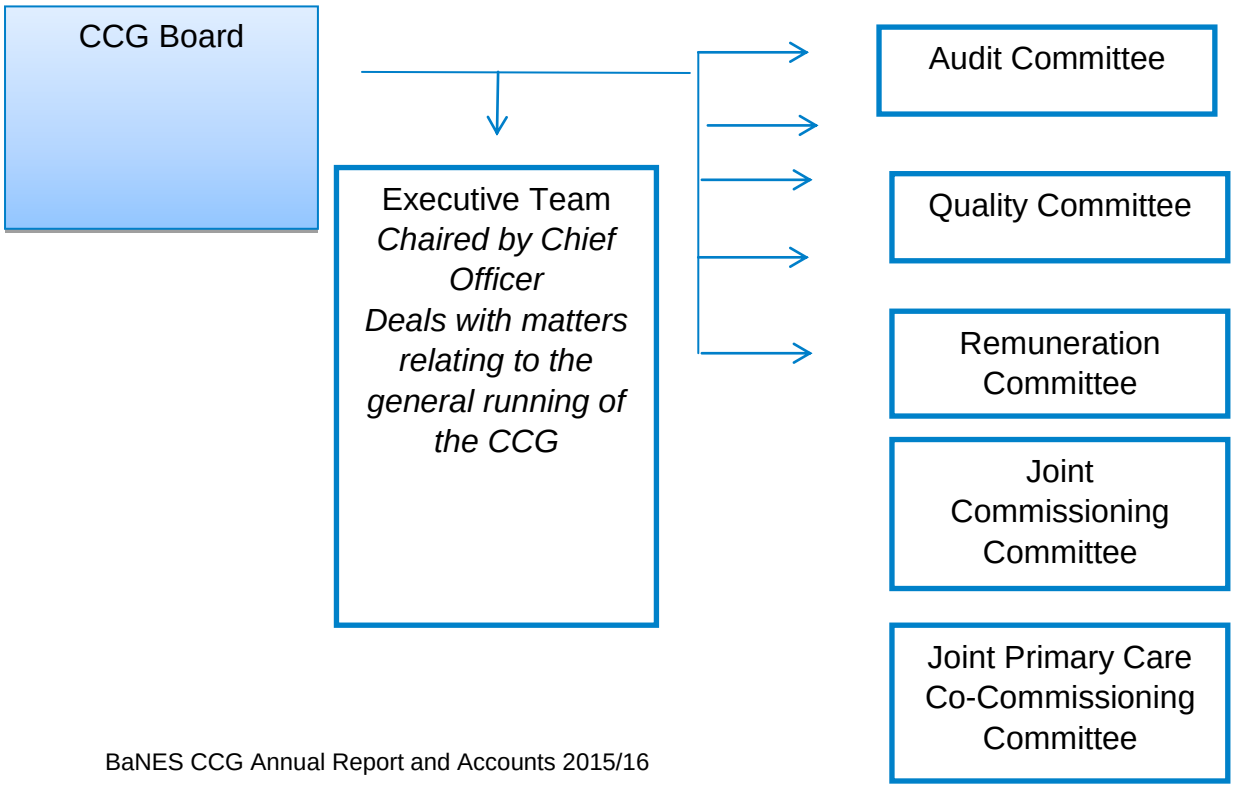
Our Board is responsible for ensuring leadership through effective oversight and review. The Board sets the strategic direction and aims to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands.

Specific key decisions and matters have been reserved for approval by the Board which are set out in clear terms of reference in the CCG's Constitution. These include establishment of, and changes, to the CCG's strategy, financial stewardship, risk management and shaping a health culture. The full formal scheme of delegation to the Board and each of its committees can be found in the CCG's Constitution on our website.

The Board reviews its terms of reference for itself and its committees annually. It last updated its terms of reference in July 2015.

To assist the Board in carrying out its functions and to ensure that there is independent oversight of internal controls and risk management, the Board delegates certain responsibilities to its sub-committees as shown below.

Governance Framework



The Chair of each committee reports to the Board on the matters discussed at their committee meetings.

Our Board's performance & effectiveness
Board performance
The clinical leadership of the organisation has continued to develop, with a 'mid-term' election bringing a new Board member, Dr Jonathan Osborn, as a result of the resignation of Dr Shanil Mantri tendering his resignation after three years' service as a GP Board representative for the CCG.

The Board members have continued their development and recognise their role as key influencers and leaders of the local health economy. The continued emphasis has been upon driving up the quality and safety of services provided to local people, reducing unacceptable variation in delivery and outcomes, underpinned by strong and effective systems, financial management and probity. Strong and effective governance arrangements are important and during the year we reviewed our performance against the UK Code of Governance for CCGs.

Our Board met eight times in public during the year, which included one extraordinary meeting. This means members of the public are welcome to attend and observe the meeting. Before these meetings there is time allocated to hold a confidential Board meeting to consider any items of business that are confidential or commercially sensitive in nature (sometimes at a point in time) and cannot be discussed in public. Items discussed in confidence included 2015/16 commissioning plans, financial matters, capacity and succession planning, procurement decisions and future strategic approach. An overview of the key areas of discussion and actions that our Board made in 2015/16 can be seen in the following table. All our Board papers are published on our website.

Key Board discussions and actions 2015/16

Date	Item
May 2015	Approved the establishment of a non-recurrent Primary Care Transformation Fund to support primary care in undertaking new ways of working. Approved commencement to stage 2 in the *your way, your care* project; a joint review between B&NES Council and BaNES CCG to review, design and deliver integrated community health and care services in partnership with local people Approved the Organisational Development Plan 2015/16 Reviewed the Staff Survey Results 2014/15 Considered the progress on the Five Year Strategy one year on Approved the amendments to CCG Delegated Financial Limits
July 2015	Reviewed the progress on the CCG's Emergency Preparedness Resilience & Response (EPRR) work plan and outline of the 2015/16 NHS England EPRR

	Core Standards Assurance process. Reviewed the Compliments, Concerns & Complaints Annual Report Approved the CCG's Confirmed Budgets for 2015/16 Reviewed the Board Assurance Framework Reviewed the Equality & Diversity Report Reviewed and approved the terms of reference for the Board's sub-Committees
September 2015	Approved the Board Annual Cycle of Business 2015-16 Reviewed Board Effectiveness and approved action plan Approved *your way, your care* Commissioning Intentions & Market Engagement Approach Approved the outline plans for the proposed approach for the planning and contracting round for 2016/17. Approved the Individual Funding Request (IFR) Annual Report Considered the Children & Adult Safeguarding Annual Report Approved the Operational Plan Deliverables Report – Q1 2015/16
November 2015	Approved the draft Commissioning Intentions for 2016/17 Approved the establishment of a Pharmaceutical Rebate Scheme Considered the Winter Resilience Planning for 2015/16 Reviewed the Health & Safety Annual Report Approved the Health & Safety Policy
December 2015 – Extraordinary meeting	Approved the Interoperability Business Case Approved the *your way, your care* Outline Business Case
January 2016	Approved for the Audit Committee to fulfil the role of the Auditor Panel Reviewed the Business Continuity/EPRR 2015/16 Reviewed the key requirements from the NHS Planning Guidance for 2016/17 Planning; production of an Operational Plan 2016/17 and Sustainability Transformation Plan Approved the changes to the CCG Constitution, including the reconfiguration of the GP clusters
March 2016	Approved the Boards Annual Cycle of Business for 2016/17 Reviewed the Declaration of Interests Annual Report Reviewed and delegated final submission of the Operational Plan for 2016/17 to the Executive Team Reviewed the progress of the Organisational Development Plan Approved the Sustainable Development Management Plan Approved the Compliments, Concerns and Complaints Policy Approved the Learning Disabilities Pooled Budget Reviewed the Information Governance Annual Toolkit Approved the creation of a Finance & Performance Committee as a Board sub-committee

Board effectiveness

The Clinical Chair of the CCG manages our Board and oversees the operation of its committees with the aim of ensuring that they operate effectively by fully utilising the diverse range of skills and experience of the various Board members. The Board and its committees are annually assessed to ensure their effectiveness is maintained, that they remain fit for purpose, and that they continue to evolve and develop to address the ever-changing environment within the NHS. Evaluating the Board's performance can lead to fresh insights into the functioning of the Board, whilst potentially identifying areas that might need to be strengthened and developed.

Board evaluation

It is accepted best practice that Boards assess and evaluate their own effectiveness in line with codes of corporate governance practice. Discerning Boards treat evaluation as a continuous improvement process that contributes towards the improvement of Board performance, transparency and ultimately improving the experience of patients and the quality of care commissioned.

The CCG has established a Board responsible for developing and monitoring strategy of the CCG, its financial and business reporting and for reviewing the effectiveness of the CCG's system of internal control. Therefore it is important that the Board carries out an evaluation in line with governance best practice.

Our Board carried out two such evaluations in 2015/16:-
A self-assessment based on a governance maturity matrix from the "*Good Governance Handbook*" published by Health Quality Improvement Partnership (HQIP). This was carried out in April and August 2015. The results showed that the Board were operating effectively. Whilst there were no areas of concern there were areas members considered the Board could improve performance which included:-

- Managing the length of Board meetings, and the balance of time given to key issues compared to routine business
- Opportunities for forward-looking review of strategic issues, and for the whole Board to contribute on strategic direction
- Clarity on the purpose and roles of Board members.

Full details of the action plan can be found on our website.

A gap analysis against the suggested achievement criteria in the NHS Code of Governance for CCGs. The aim of the code was to develop a concise document that outlined governance principles that support clinicians and those that work with them to perform their commissioning activities and help maintain public trust in clinicians and the NHS. It is a voluntary document but it is good practice to review

activities to confirm compliance and to note and explain areas of non-compliance. The NHS Code is available on the ICSA Governance Institute website.

The analysis was presented and reviewed by the Audit Committee in February 2016 and confirmed that the CCG is able to demonstrate compliance in the majority of areas.

Induction of new Board Representatives

On appointment, each new member of the Board undertakes a tailored comprehensive induction programme which introduces the new member to the CCG's business and its senior management. On 1 February 2016 Katie Hall joined the CCG as Associate Lay Member and on 1 March 2016 Dr Jonathan Osborn joined as GP Board Representative. They undertook the following as part of their induction:-

- Had individual meetings with the executive directors and senior managers
- Attended Board and its sub-committees and seminars
- Received relevant documentation

Training

Appropriate training and briefing is provided to all Board members on appointment, taking into account their individual experience and responsibilities. Ongoing training is arranged to suit their specific needs and the Chair regularly reviews and agrees with each Board member their training and development needs. In 2015 the independent lay members completed training on conflicts of interest and primary care finances.

Independence of lay and clinical members

The decisions required of CCGs are broad and cover all aspects of the local health economy. The strength of lay and independent clinical members can be in their capacity to maintain the sensitivity of the Board to the magnitude and impact of their decision. The ability to interrogate and challenge decisions and ways of operating are key to the value lay and independent clinical members bring to the Board. They are able to do this given their independence from the immediate operational concerns of the CCG. To further enhance oversight of the CCG, all of the Board sub-committees, with the exception of the Joint Commissioning Committee, are chaired by a lay member.

Attendance at board and committee meetings						
	Board	**Audit Committee**	**Quality Committee**	**Remuneration Committee**	**Joint Commissioning Committee**	**Joint Primary Care Co-Commissioning From July 2015**
Dr Ian Orpen	**7/8**	**n/a**	**n/a**	**1/1**	**n/a**	**n/a**
Tracey Cox	**8/8**	**5/6***	**1/6**	**n/a**	**11/11**	**n/a**
Dr Ruth Grabham	**7/8**	**n/a**	**6/6**	**n/a**	**9/11**	**1/2**
Dawn Clarke	**6/8**	**4/6***	**5/6**	**n/a**	**7/11**	**2/2**
Sarah James	**7/8**	**4/6***	**n/a**	**n/a**	**9/11**	**2/2**
Dr James Hampton	**6/8**	**n/a**	**n/a**	**n/a**	**8/11**	**n/a**
Dr Elizabeth Hersch	**6/8**	**n/a**	**n/a**	**n/a**	**7/11**	**n/a**
Dr Shanil Mantri	**4/7**	**n/a**	**n/a**	**n/a**	**7/10**	**n/a**
Dr Daisy Curling	**6/8**	**n/a**	**5/6**	**n/a**	**11/11**	**n/a**
Dr Jonathan Osborn	**1/1**	**n/a**	**n/a**	**n/a**	**1/1**	**n/a**
Helen Harris	**7/8**	**n/a**	**n/a**	**n/a**	**8/11**	**2/2**
Myles Taylor	**6/8**	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**
Suzannah Power	**6/8**	**4/6**	**4/6**	**1/1**	**n/a**	**2/2**
John Holden	**8/8**	**6/6**	**5/6**	**1/1**	**n/a**	**2/2**
Katie Hall	**n/a**	**1/1**	**n/a**	**n/a**	**n/a**	**1/1**
*indicates regular attendance						

Audit Committee

This committee provides the Board with an independent and objective view of the CCG's internal control and financial reporting arrangements. This includes reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, seeking assurance on compliance with laws, regulations and codes of conduct, ensuring effective internal audit and counter-fraud functions are in place, reviewing the work and findings of external audit and the CCG's response and monitoring the arrangements for and outputs of the CCG's financial reporting systems.

The Chair of the Audit Committee has relevant financial experience gained during a career in industry and the Civil Service (see membership body and board profiles) and he also has served on equivalent committees in other NHS organisations and Home Office agencies.

The significant areas of business discussed by the Audit Committee during the year were:-

Date	Item
April 2015	Draft Core Policies Review – a plan to ensure the CCG has a comprehensive and appropriate set of policies in place which are up to date Annual Accounts and Annual Report – a review of the draft documents Internal Audit reports and Head of Audit Opinion – a range of reports were discussed Internal Audit and Counter Fraud – work plans for the year were approved Continue Healthcare progress update – positive progress was discussed but agreement to keep under review
May 2015	Annual Accounts and Annual Report – reviewed final versions together with External Audit Findings Report and recommended these to the Board A review of the new format Board Assurance Framework Received the Counter Fraud Annual Report
July 2015	Reviewed the depth and breadth of reports from other committees which it would be appropriate for the Audit Committee to oversee. Received reports on counter-fraud activity and plans. Approved the Annual Report of the Chair of Audit,to go to the September 2015 Board in public Received Internal Audit progress report and audit recommendation tracker and External Audit's (wholly positive) Annual Audit Letter. Conducted our annual Audit Committee self-assessment
October 2015	Review of Personal Health Budgets Review of Financial Control Environment Four internal audit reports. All demonstrated **significant assurance** CSU Contract Performance Management GP Payments Conflicts of Interest Risk Management

	Reports were received from: Counter Fraud External Audit Security Management Policy was recommended to Joint Commissioning Committee.
December 2015	Reviewed updated risk register and proposed changes to counter-fraud policy Agreed to use the Audit Committee as the body to oversee External Auditor appointment. Received progress report on internal audit Reviewed business continuity plan Agreed way forward on reporting key concerns from CCG committees to Audit Committee.
February 2016	A review of the NHS Code of Governance and our compliance Approval of the counter fraud work plan Receipt of a set of very positive internal audit reports: Pooled budgets Core financial systems Performance management Committee effectiveness Compliance with core policies A review of the risk register and board assurance framework External audit update and audit plan.

The Audit Committee's terms of reference were reviewed in July 2015. They were subsequently reviewed and amended in January 2016 to reflect additional responsibilities of functioning as Auditor Panel to oversee External Auditor appointment.

Remuneration Committee
See Remuneration Report.

Quality Committee
The membership is as follows:-

Quality Committee Members (voting)	
Suzannah Power	Committee Chair and Lay Member (Patient & Public Involvement)
Dawn Clarke	Director of Nursing & Quality / Registered Nurse
Dr Ruth Grabham	Medical Director
Dr Daisy Curling	GP
Tracey Cox	Chief Officer
John Holden	Lay Member (Audit & Governance)
A Public Health Representative	
Representative from Healthwatch	

The Quality Committee is accountable to the CCG Board, and exists to discharge the clinical governance and quality functions of the CCG. The Quality Committee is responsible for scrutinising and providing assurance of the continual improvement in quality of all commissioned services. One significant area of responsibility for Quality Committee is the requirement to hold providers to account through structured contractual mechanisms.

Quality Committee provides the necessary oversight for a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience.

Patient safety: commissioning high quality care which prevents all avoidable harm and risks to the individual's safety, and having systems in place to protect patients.

Clinical effectiveness: commissioning high quality care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes, and making sure care and treatments achieve their intended outcome.

Patient experience: commissioning high quality care which gives the individual as positive an experience of receiving and recovering from the care as possible, including being treated according to individual want or need, being listened to, and being treated with compassion, dignity and respect.

Our Lay Member Patient & Public Involvement chairs this committee and is supported by a Vice Chair, also a Lay Member of the CCG, and Chair of the Audit Committee. Healthwatch representatives ensure that the patient voice is heard throughout the course of the Committee's meetings. Quality Committee integrates closely with the other CCG committees to ensure there is alignment of activity and to avoid duplication. The Quality Committee meets bi-monthly. Its terms of Reference were reviewed in July 2015.

Safeguarding

Throughout 2015/16 we have continued to meet statutory requirements in relation to safeguarding adults and children. The Director of Nursing and Quality participates in the Safeguarding Adults and Safeguarding Children Boards.

The Quality Committee has overseen the quality team's work in supporting the requirements of the Care Act 2014 and NHS England's safeguarding assurance framework, through the tightening of requirements of our providers and the role and contribution of the safeguarding professional aligned to the CCG. We have been assured that this year our providers have been compliant with national and local requirements. This year the CCG continued to have good engagement with its

member practices and robust safeguarding policies and procedures are in place and understood.

Medicines optimisation

During 2015/16 the CCG has worked collaboratively with other health professionals and social care providers to deliver evidence-based cost effective use of medication to improve patient outcomes and patients' experiences of treatment.

The CCG's Medicines Optimisation Team has reported regularly to Quality Committee, covering prescribing plans, performance against indicators and NICE Guidelines. Of note were the detailed Asthma Audit and a survey of patients requiring anticoagulation monitoring, both of which have been utilised to improve services for patients and carers.

The Quality Committee met six times during the year and significant areas of business include:

- Month by month review of the clinical quality performance standards of our health care providers
- The development and delivery of a detailed primary care dashboard
- Detailed thematic analysis of PALS reports, Complaints audits and Healthwatch summaries
- Deep dives into areas of particular concern, bringing together data, intelligence and qualitative insight on commissioned services including NHS111, BDUC and Arriva Transport
- Agreement and oversight of CQUIN schemes
- Reporting and progress assurance around NHS Continuing Healthcare (CHC) and Funded Nursing Care (FNC) for Adults and Children
- Personal Health Budget audits around cost and quality
- Delivery of a commissioner-led quality assurance visit programme and oversight of the improvement actions required for better patient experience
- Nursing Home and Care Home quality reports including quality dashboard development and introduction of Friends and Family Testing for residents
- Oversight of the programme of clinical research and implications for practice
- Assurance that our providers have implemented the Public Sector Equality and Diversity requirements
- Quarterly assurance that we meet statutory Adult and Children's Safeguarding requirements.
- Its terms of reference were reviewed in July 2015.

Joint Commissioning Committee

The Joint Commissioning Committee strengthens our partnership arrangements with the Council. The membership is as follows:-

Joint Commissioning Committee (voting)	
CCG Members	
Tracey Cox	Committee Chair and CCG Chief Officer

Sarah James	Chief Financial Officer
Dr Ruth Grabham	Medical Director
Dawn Clarke	Director of Nursing and Quality
Corinne Edwards	Head of Commissioning Development
Council Members	
Ashley Ayre	Strategic Director for People & Communities
Jane Shayler	Director, Adult Care and Health and Commissioning
Dr Bruce Laurence	Director of Public Health
Richard Morgan	Council Finance Manager
Clinical Members	
GP Cluster Commissioning Leads	
Practice Manager Cluster Commissioning Lead	

The committee receives a number of regular reports: the Joint Partnership Risk Register; the Integrated Quality and Performance Report; Finance and QIPP reports from the CCG and Council. The Committee also reviews QIPP plans for the forthcoming year.
Significant areas of business discussed by the Joint Commissioning Committee during the year were:-

Date	*Item*
April 2015	***Your Care Your Way***; a gateway report following the end of phase 1. The proposed approach for phase 2 of the project was approved. 5 Year Strategy Transformation Projects; a progress report on the end of year position for the transformation projects of the five year strategy against the key milestones set. Independent Sector Treatment Centre (ISTC); a report updating on the progress with the re-procurement of services currently provided by the Independent Sector Treatment Centres. Leader Provider Framework; outlined the timescales and approach to re-procure current CSU contracts which expires at the end of March 2016. Organisational Development Plan; describes the organisational development plan to support the delivery of the CCG's organisation's strategic objectives
May 2015	Diabetes Primary Care Local Enhanced Services (LES) LES Review CCG's Role in Addressing Health Inequalities Progress Report – Transition of 0-5 Services (Health Visiting & Family Nurse Partnership

	Lead Provider Framework Communications & Engagement Strategy CCG Confirmed Budgets School Improvement & Achievement Policy Reviewed Committee Terms of Reference
June 2015	NHS 111 Review Quality Premium for 2015/16 Autistic Spectrum Disorder (ASD) Investment Family Support Service Commission Personalisation in Health & Social Care Procuring Commissioning Support Services Better Care Fund Update
July 2015	Maternity Services Hip & Knee Evaluation Community Dermatology Service Update Future Plans for use of £5 per head allocation Diabetes Specialist Nursing Procurement *"your care, your way"* update Mental Health update – Inpatient Redesign Commissioning Support Services Update (Lead Provider Framework) Management of Change Policy
August 2015	*"your care, your way"* Draft Commissioning Intentions & Market Engagement Approach GP Forum and Cluster Development Strategy Mental Health – AWP Payment Development Update Referral Support Service Update
September 2015	Primary Care : Preparing for the Future Progress Report Mental Health : Wellbeing College Extension Apronectomy/Abdominoplasty Policy Review MSK Update ISTC Procurement Update Pharmaceutical Rebate Schemes Proposal for the Provision of Community Wound Dressings Quality Premium 2014/15 Update "your care, your way" Update Local Transformation Plan for Children and Young People's Mental health & Wellbeing Transition 0-5 Services Update
October 2015	Personalised Health & Care 2020 & Local Digital Roadmaps Clinical Commissioning Intentions 2016/17 Mental Health Update : In-patient redesign Planning Round Update

	Security Management Policy
Nov 2015	*"your care, your way"* : Outline Business Case, Market Testing & Service Outcomes Diabetes Pathway Redesign Programme Update NHS 111 Update Sufficiency Statement : Looked After Children's Statement Personal Budgets Policy Early Help Strategy for Children, Young People & Families 2015-18
December 2015	No meeting was held
January 2016	Dorothy House- Assisted Discharge Service Review BEMS+ Preparing for the Future Progress Report MSK Update : Hip & Knee Programme Referral Support Service (RSS) Implementation Report Medicines Management Strategy Mental Health : In-patient Redesign Outline Business Case Update Supporting People & Communities Funded Services : Contract Extensions Annual Commissioning Intentions - People & Communities Directorate IG Policies for approval
February 2016	Map of Medicine Implementation Report Re-commissioning CAMHS Contract your care, your way Update Home Oxygen Re-procurement Planning 2016/17 Update Q3 CSU Workforce Report 2015/16 Quarterly Incident Report Anti-Fraud Policy Other Leave Policy
March 2016	Evaluation of Focus Weekend Working AWP : Re-provision of Hillview Lodge Designs Minor Injury Unit Review Better Care Fund 2016/17 Review Avon and Somerset LHRP Influenza Pandemic Framework Operational Plans 2016/17 Update Organisational Development Plans Update Sustainability Report and Action Plan Update Communications & Engagement Strategy Update Mobile Computing Leaflet

Terms of reference for the Joint Commissioning Committee were reviewed in July 2015.

Joint Primary Care Co-Commissioning Committee

The Joint Primary Care Co-commissioning Committee is a newly created committee for 2015/16 to support joint arrangements between our CCG and NHS England (NHSE) in the commissioning and designing of primary care services.

NHS England Chief Executive Simon Stevens announced on 1 May 2014 that CCGs could choose to expand their role in primary care commissioning and assume greater power and influence over the commissioning of primary medical care from April 2015.

CCGs were offered three options, and Bath and North East Somerset CCG opted to jointly commission primary medical services with NHS England.

Joint commissioning of services is enabling the CCG and NHSE to develop seamless, integrated out-of-hospital services and helps to drive the development of new models of care and improve services for patients. Furthermore, this new way of working supports the delivery of our strategy, and means we have greater influence across the entire local health system and helps us to change the way we deliver services so more are provided out of hospital in the community.

The BaNES CCG and NHS England Joint Primary Care Commissioning Committee (JPCCC) was established on 1 April 2015. It is a joint committee tasked with the primary purpose of carrying out the functions relating to the commissioning of primary medical services (under Section 83 of the NHS Act) except those relating to individual GP performance management, which is the responsibility of NHS England. The terms of reference of the Committee reflect relevant national guidance. The JPCCC met on two occasions during 2015/16. At the inaugural meeting, the committee reviewed its terms of reference and work programme, received a report from the Primary Care Operational Group and a presentation regarding primary care in B&NES. At the second meeting, the committee reviewed and approved the terms of reference for the Primary Care Operational Group, received an update from Healthwatch and approved plans for re-investment of the Primary Medical Services Premium.

JPCCC meetings are held in accessible venues throughout Bath and North East Somerset and are well attended by the public. Membership of the Committee is as follows:-

Joint Primary Care Co-Commissioning Committee (voting)	
CCG Members	
Suzannah Power – Chair	Lay member
Dawn Clarke	Director of Nursing and Quality
Corinne Edwards	Head of Commissioning Development
Dr Ruth Grabham	Medical Director and GP Representative
Helen Harris	Practice Manager

John Holden	Lay Member
Sarah James	Chief Financial Officer
NHS England Members	
Debra Elliot	Director of Commissioning, South Central
John Trevains	Assistant Director of Nursing, Quality & Safety, South Central
Dean Walton	Finance Manager, South Central
LMC rep	
Kate Jenkins	GP

Part way through the year the membership was changed to include a nursing & quality representative from NHSE, and the CCG appointed an Associate Lay member to strengthen independent scrutiny.

Conflicts of Interest

One of our priorities is to manage any conflicts of interest, to ensure that conflicts do not occur and compromise the integrity of the decision-making process within JPCCC. We have followed and will continue to follow best practice as set out in the National Framework for Conflicts of Interest in Primary Care (published December 2014) and the CCG's Standards of Business Conduct Policy when commissioning primary care medical services. The JPCCC has conducted a thorough audit of potential conflicts and a Register of Declared Interests is kept and updated throughout the year. The CCG has appointed an Associate Lay Member who will address quoracy issues within the Audit Committee and to strengthen independent scrutiny at the joint primary care co-commissioning committee.

Our Internal Auditors completed a "Committee Effectiveness" review in February 2016 and based on findings of their work, **significant assurance** was provided for our committee governance arrangements.

Joint Working Framework

We have established integrated working arrangements with the Council, with a particular emphasis on joint commissioning of services.

Our vision is to commission high quality, affordable, integrated patient centred care which respects and responds to the needs of our local population, harnessing the strength of clinician led commissioning and empowering our patients to improve their health status. This is summarised as 'Healthier, Stronger, Together'.

The Council's vision is for B&NES to be an area where everyone fulfils their potential; with lively, active communities; with unique places and beautiful surroundings. Key objectives are promoting independence and positive lives for everyone, creating neighbourhoods where people are proud to live and building a stronger economy.

The vision for joint working is that by working together, both organisations are stronger; we can achieve more together; and effectively drive forward the delivery of

the strategic aims of the Health and Wellbeing Board. The aims and intended outcomes of joint working are:

Aims:

- To align strategy, service plans and use of resources
- To commission, manage and deliver high quality Services which understand and respond to the needs of individual patients, service users and their carers
- To ensure integrated delivery of seamless care through effective commissioning
- To make the best use of management and professional skills and knowledge
- Efficiency and value for money.

Expected outputs:

- Shared strategy and priorities
- A shared understanding of need and demand for health and care
- Joint development and investment plans
- Aligned business planning and performance management arrangements
- Clearer and more efficient communication with stakeholders
- Greater opportunities to influence
- Efficiency savings.

Expected outcomes:

- Better services for local people
- Delivery of key priorities set out in the Joint Health and Wellbeing Strategy
- Effective delivery of the CCG's and Council's respective published plans, capitalising on synergies and interdependencies between the two organisations
- Sustaining and improving both CCG and Council performance against a range of national outcome indicators.

Achieved through:

- An integrated leadership structure and joint management teams
- Alignment of systems and policies
- Building on positive relationships
- Sharing space and support services.

These arrangements are supported by a Joint Working Framework and a Joint Committee for Oversight of Joint Working oversees the operation of all joint working arrangements.

The membership of this committee comprises:

- The CCG's Chair and Chief Financial Officer

- The Executive Members responsible for Adult Social Care and Children's Services (Council)
- The Council's Chair of Audit Committee
- The CCG Chair of Audit Committee

The CCG and Council have a joint partnership risk register and an integrated quality and performance report.

Better Care Fund
We have agreed arrangements for use of the Better Care Fund (BCF) within B&NES. The BCF builds on our existing pooled and aligned financial arrangements to further realise the benefits of integrated commissioning and provision. Led by the Health & Wellbeing Board, our focus is on prevention and early intervention, solutions across health and social care to support hospital discharge and prevent avoidable admissions, and a new focus in 2016/17 on technology. Further context is provided by *your care, your way* which sets out our commitment to maintaining independence and supporting people at all stages of their lives. To support the CCG to monitor the performance of the BCF, we have agreed a number of Key Performance Indicators including the number of Delayed Transfers of Care (DTOCs) and emergency admissions and we have established a performance dashboard for the BCF which is reviewed regularly by the Joint Commissioning Committee.

Health and Wellbeing Board
Health and Wellbeing Boards are a forum where key leaders from the Health and Care System work together to improve the health and wellbeing of their local population and reduce health inequalities. Dr Ian Orpen is Joint Chair of the B&NES Health and Wellbeing Board alongside Councillor Vic Pritchard. Our Joint Health and Wellbeing Strategy sets out the priorities for joint action based on the health and wellbeing needs identified in B&NES.

The three themes in our strategy are:

- Preventing ill health by helping people to stay healthy
- Improving the Quality of people's lives
- Tackling health inequality by creating fairer life chances

Our Risk Management Framework

The risk and control framework encompasses the key assurance systems including planning, performance monitoring, audit, management policies and procedures, external assessment and risk management. The operation, scrutiny and reporting of these systems assists internal control.

The CCG is required to have in place an assurance framework that will enable the Board to be confident that the systems, policies and people they have put in place

are operating in a way that is effective, is focused on key risks and is driving the delivery of priorities. The CCG has such a framework in place. The assurance framework, which was updated in 2015/16 to reflect recommendations of our auditors, outlines the systems in place to manage delivery of our strategic objectives and control the risks to those objectives. It details where assurances on the effectiveness of the system can be obtained, where there are gaps in assurance or control and any actions required to resolve these.

During the year, gaps in both controls and assurance were identified through the management of the assurance framework. Work took place to address the identified gaps through agreed controls and the monitoring of their implementation. Progress was reported regularly to the Audit Committee and the Board and by the end of 2015/16 there were no significant actions outstanding.

The risk management strategy describes the organisational responsibilities for risk management, the role of all managers and clinicians and the involvement of all staff in the ownership of, and commitment to, reducing risks. The strategy sets out the CCG's strategic direction for the management of risks and provides the framework for the continued development of risk management processes throughout the CCG. The strategy covers in detail the following areas; strategic objectives for risk management; risk management framework and approach; roles and responsibilities; risk management process; risk identification, assessment and measurement; risk appetite and risk reporting and monitoring.

A system of counter fraud has been in operation throughout 2015/16. Working to a managed plan, the counter fraud service has undertaken activities that seek to further establish an anti-fraud culture to deter fraud, prevent fraud, detect fraud and investigate fraud where it is suspected.

The Chief Financial Officer has overall responsibility for setting the framework, policies and procedures that enable sound financial control and financial risk management. These have been in place throughout the year, with all staff responsible for complying with relevant aspects.

The Board and the Quality Committee are involved in setting priorities and monitoring progress for Equality, Diversity and Human Rights. The CCG has a robust recruitment and selection process to support a fair recruitment process.

The CCG recognises it can only deliver the very best local health services by putting the public and patients at the heart of everything it does. Therefore we are committed to ensuring that we listen to and involve them effectively and systematically at every stage in the commissioning process. Please refer to the Performance Report for more about how we use patient insight to improve health services and how we seek to reduce health inequalities that exist across the region.

Risk Assessment

As described above, the CCG's Board Assurance Framework enables Board members to be confident that the systems, policies and staff they have put in place are operating in a way that is effective and is focused on the delivery of organisational objectives. The CCG Board reviewed the assurance framework throughout 2015/16 and was audited by the internal auditors in October 2015 with an overall RAG rating of green 'significant assurance'. The Audit Committee is responsible for monitoring the assurance framework and recommends it to the Board. The Board reviewed the assurance framework in July 2015 and March 2016. The assurance framework details:

- The key business objectives
- The principal risks to the achievement of objectives
- The key controls against the respective principal risks
- The gaps in control and the gaps in assurance that have been identified
- Action plans to remedy any gaps
- The arrangements for accountability and responsibility.

The key business objectives identified in the Board Assurance Framework for 2015/16 were: delivering operational plans, delivering transformational change; and delivering strategic priorities.

The CCG has an organisation-wide risk register that covers the risks identified and provides risk analysis. In addition, the CCG has identified the risks associated with the strategic objectives outlined within the CCG assurance framework and covers the following aspects of risk:

- Nature of risk
- Classification of risk
- Risk rating
- Review date
- Actions

Any organisational risks assessed at a score of 12 or above or which are deemed to be an emerging risk are referred to the Audit Committee for consideration and monitoring. The Joint Commissioning Committee also reviews the corporate risk register which includes all risks with a score of 15 or above and reviews the whole risk register on a quarterly basis. Risks assessed at a score of 15 or above are reported to the Board.

Executive directors are fully engaged with the system to maintain and update the Board assurance framework and risk register.

Risks are systematically identified, evaluated and controlled by each directorate within the CCG. Significant risks are identified and reported in the organisation-wide risk register.

The risk profile of the CCG is represented in a partnership risk map which is reviewed by the Audit Committee and the Joint Commissioning Committee.

Generally, the risks identified against the strategic objectives are those relating to the CCG's service plans, financial plans, quality plans and capability and capacity to deliver on its objectives.

Our Operational Plan for 2015/16 identified the key risks during this period as: sustaining and improving performance against the 4-hour A&E waiting time target; reducing RTT backlogs and then maintaining good performance; delivering reductions in non-elective admissions as part of the BCF plan; maintaining our capacity to deliver significant programmes of change and sustaining the health and wellbeing of our staff; and delivery of QIPP targets.

Our risk profile has increased during 2015/16 with five high scoring risks on the corporate risk register in May 2015, rising to ten corporate risks by March 2016. The risks discussed by the Board, the Audit Committee and the Joint Commissioning Committee have consistently included the performance of the urgent care system; delivery of the 4 hour waiting time target in A&E; referral to treatment times; and at the beginning of the year, NHS 111 performance and poor patient experience in the non-emergency patient transport service. Later in the year, risks have emerged associated with commissioning support services re-procurement; capacity and capability concerns; delivery of a primary care strategy; and latterly more significant financial risks relating to increases in contracted activity and the risk to our financial surplus target with concerns about our financial position in 2016/17.

Our Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

The CCG Board reviews and approves corporate objectives for the organisation at the beginning of the financial year. These objectives provide a framework against which the executive directors create their own objectives and for members of their teams. In this way, the efforts of all staff are harnessed to deliver the objectives of the organisation.

Information Governance

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

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook. There are processes in place for incident reporting and investigation of serious incidents.

We received assurance in respect of commissioning support functions via full access to their service auditor reports.

Data Quality

The CCG has developed a robust process for assuring data quality with its providers as part of its contractual mechanisms. Key metrics pertaining to quality of provider data, such as NHS number, are monitored on a routine basis by the CSU along with progress against priorities in each provider's data quality improvement plan. Variances are highlighted to providers for rectification and followed up through routine meetings to ensure accurate and reliable provider data. This ensures that data relied on by the Board and Council of Members is of sound quality to support performance management and decision making.

Business Critical Models

The CCG has in place an appropriate and proportionate approach to providing quality assurance of business critical models, in line with the recommendations of the Macpherson Report.

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment, achieving Level Two. The CCG had one breach of data security during
2015/16. This lapse of data security was reported immediately to the Information Commissioner and has been confirmed as being at severity 0 (minor breach). The Information Commissioner was satisfied with actions taken by the CCG.

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

The CCG has sound processes for financial management and performance management across the range of its commissioned services and running costs. The financial management and budgetary control framework and supporting guidance provide a structure for the exercise of financial control, and regular performance monitoring enables review of the quality and productivity of commissioned services.

These are underpinned by a commitment to understanding and improving data quality, ensuring that assessments of value for money are based on valid information and correctly interpreted. The Joint Commissioning Committee and Board review performance including quality, productivity and financial aspects at every meeting.

As the CCG's financial position has become more challenging, performance management and monitoring arrangements have been reviewed to ensure they remain fit for purpose, with quarterly performance review content refreshed and the development of a Finance and Performance Committee for 2016/17.

The CCG uses benchmarking and other comparative data, procurement and market testing, and individual service review to test the value for money of commissioned services. Where services are determined not to be providing good value, improvement plans are implemented. This is underpinned by the CCG's strategic planning approach, which recognises continuous testing of value for money and takes action to release resources that are not being used to best effect, as essential to successful commissioning.
Internal Audit considers value for money in their reviews and where appropriate makes recommendations to improve data quality, effectiveness, efficiency and productivity.

Review of the effectiveness of Governance, Risk Management & Internal Control

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

Capacity to Handle Risk

The Board, the Audit Committee, the Joint Commissioning Committee, the Chief Officer and the executive directors provide leadership to the risk management process. The risk management strategy details the responsibilities of staff. The risk management systems have been audited recently with positive assurance provided. Recommendations for further enhancement are being implemented.

Review of Effectiveness

My review of effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by external auditors in their management letter and other reports.
The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principal objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Board has contributed to the effectiveness of the system of internal control by approving and reviewing the Board Assurance Framework and risk register and receiving reports from committees. The Board receives progress reports on the achievement of the strategic and corporate objectives as part of the regular performance review.

The Board reviews financial, service delivery and quality performance at every meeting and receives periodic reports regarding delivery of statutory and other obligations including in relation to: the public sector equality duty; partnership responsibilities, in particular to develop joint health and wellbeing strategies; securing public involvement; delivery of the NHS Constitution; securing continuous improvement in the quality of services and the management of emergency preparedness, resilience and response.

The Audit Committee has also evaluated the Board Assurance Framework and risk registers and systems of risk management and internal control in detail. The Audit Committee advises the Board on the controls and assurance documented within the framework. Progress on improving internal controls and removing gaps in control and assurance is monitored by this committee and its work is reported to the Board.

The Audit Committee has reviewed progress in the establishment of an appropriate policy framework for the CCG during 2015/16. The Audit Committee has also received reports regarding the progress of internal and external audit and counter fraud and reviewed best practice guidance relating to governance arrangements. The Audit Committee has received audit reports and monitored action plans in relation to these. The Audit Committee reviewed their performance and has provided an annual report at the May 2014 Board meeting.

The Quality Committee has contributed to the maintenance and review of the systems of internal control by providing assurance on the quality of services commissioned and supporting a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience. In addition, this committee has ensured there are robust systems in place to safeguard adults and children; monitored arrangements to ensure compliance with equality and diversity obligations; ensured delivery of requirements for information governance; ensured systems are in place to support the governance of research; and reviewed reports on serious incidents and never events occurring in commissioned services.

My review is also informed by internal and external audit reports, the contribution of external auditors and the counter fraud service and the perspective provided by other external bodies, for example NHS England and the NHS Litigation Authority.

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:

Our opinion based for the period 1 April 2015 to 31 March 2016 is that:

'Substantial assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.'

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1 April 2015 to 31 March 2016 inclusive, and is based on the ten audits that we completed during 2015/16. We will present this to the Audit Committee for approval at its April 2016 meeting.

The design and operation of the Assurance Framework and associated processes

In accordance with our Internal Audit Plan for 2015-16, we have not undertaken a formal review of the Trust's Assurance framework during the year. Through observations at Audit Committee meetings, we have confirmed that the Board Assurance Framework is reviewed on a regular basis by the Committee and is provided to the Board for further discussion.

We have completed a review in relation to the risk management processes at the Trust, and issued a 'significant' assurance rating with two low priority recommendations. All of the recommendations raised from previous reviews have been implemented by the CCG.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year

We issued no 'limited' assurance ratings in respect of 2015/16 assignments. We issued three 'significant assurance with minor opportunities to improve ratings in 2015/16, and seven 'significant' assurance ratings.

The above findings result in us issuing a 'substantial' assurance opinion in respect of the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

KPMG LLP

Chartered Accountants
Bristol

April 2016

Discharge of Statutory Functions
The arrangements put in place by the CCG and explained within the corporate governance framework were developed with extensive expert external legal input, to ensure compliance with all the relevant legislation. That legal advice also informed the matters reserved for Council of Members and Board decision and the scheme of delegation.

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

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

Conclusion
No significant internal control issues have been identified.

Signed : **Date:**

Sarah James
Deputy Accountable Officer
Signed for and on behalf of Accountable Officer

Remuneration Report

Remuneration Policy
Amendments to salary are determined annually by the Remuneration Committee. Salaries exclude on-call payments. Senior Manager performance is monitored through the formal appraisal process, based on organisational and individual objectives.

Remuneration is designed to fairly reward each individual based on their contribution to the CCG's success taking into account the need to recruit, retain and motivate skilled and experienced professionals. Remuneration must take into account considerations of equal pay, value for money in the use of public resources, and the CCG's obligation to remain within its financial allocations.

Executive Directors pay is set in accordance with the guidance *Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officers*. Existing 'very senior manager' pay scales, terms and conditions apply.

For other Board members, the CCG relies on available guidance and comparative data from other NHS organisations and CCGs to determine appropriate remuneration packages. In the case of GP members, a comparison with salary in their general practitioner role is also taken into account along with any loss of seniority pay due to the time commitment to the CCG.

Remuneration Committee

Remuneration Committee Members (voting)	
John Holden	Lay Member (audit and governance) / Chair
Suzannah Power	Lay Member (patient and public involvement)
Dr Ian Orpen	Chair of the CCG
HR specialist	South Central and West CSU (in attendance)

The CCG has a Remuneration Committee, the role of which is to make recommendations on the remuneration and conditions of service of staff, and to approve remuneration and conditions of service of Board members and people who provide services to the CCG and to evaluate the performance of members of the Board.

During 2015/16 one formal meeting of the CCG Remuneration Committee was held.

Senior managers performance related pay
The CCG currently has no policy for awarding performance related pay to senior managers or other staff.

Policy on senior managers contracts
Executive senior managers are on permanent NHS contracts, with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and 'very senior manager' arrangements.

Senior managers service contracts
The contracts for senior managers who are elected or appointed for a fixed term of office include specific reference to the fixed term nature of the appointment and the related end date. There is no provision for compensation for early termination. Terms of office, notice periods and grounds for early termination are set out in the CCG's Constitution.

	Start date	Unexpired term at 31.03.2016	Notice period
Dr Ian Orpen, Chair of the CCG	**01.04.2013**	**1 year**	**6 months**
Dr Ruth Grabham, Medical Director	**01.04.2013**	**1 year**	**3 months**
Dr Shanil Mantri , GP Cluster Lead	**01.04.2013**	**Stepped down 29.2.16**	**3 months**
Dr James Hampton, GP Cluster Lead	**01.04.2013**	**1 year**	**3 months**
Dr Elizabeth Hersch, GP Cluster Lead	**01.04.2013**	**3 years**	**3 months**
Helen Harris, Practice Manager Cluster Lead	**01.06.2013**	**1 year 2 months**	**3 months**
John Holden, Lay Member (Audit and Governance)	**01.10.2012**	**6 months**	**3 months**
Mr Myles Taylor, Secondary Care Consultant	**01.06.2014**	**2 years 2 months**	**1 month**
Suzannah Power, Lay Member (Patient and Public Involvement)	**01.02.2014**	**1 year 10 months**	**3 months**
Dr Daisy Curling, Sessional GP Board Member	**9.10.2014**	**2 years 6 months**	**3 months**

Dr Jonathan Osborn, GP Cluster Lead	**1.3.16**	**3 years 11 months**	**3 months**

NHS Bath and North East Somerset Clinical Commissioning Group - remuneration of senior managers 2015-16 - Audited

Name and title	From	To	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£00	£000	£000	£000	£000
Dr Ian Orpen, Chair of the CCG	01/04/2015	Present	85-90	2	0	0	10-12.5	100-105
Dr Ruth Grabham, Medical Director	01/04/2015	Present	80-85	0	0	0	5-7.5	90-95
Tracey Cox, Chief Officer	01/04/2015	Present	110-115	2	0	0	80-82.5	190-195
Sarah James, Chief Financial Officer	01/04/2015	Present	85-90	3	0	0	0-2.5	90-95
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	01/04/2015	Present	80-85	0	0	0	7.5-10	90-95
Dr Shan Mantri, GP Cluster Lead	01/04/2015	29/02/2016	20-25	0	0	0	2.5-5	25-30
Dr Elizabeth Hersch, GP Cluster Lead	01/04/2015	Present	25-30	0	0	0	2.5-5	30-35
Dr Daisy Curling, GP Cluster Lead	01/04/2015	Present	25-30	0	0	0	70-72.5	95-100
Dr James Hampton, GP Cluster Lead	01/04/2015	Present	30-35	0	0	0	N/A	30-35
Dr Jonathan Osborn, GP Cluster Lead	01/03/2016	Present	0-5	0	0	0	15-17.5	15-20
Mr Myles Taylor, Secondary Care Representative	01/04/2015	Present	10-15	1	0	0	N/A	10-15
Helen Harris, Practice Manager Representative	01/04/2015	Present	10-15	0	0	0	N/A	10-15
John Holden, Lay Member for Assurance and Governance	01/04/2015	Present	15-20	1	0	0	N/A	15-20
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2015	Present	15-20	2	0	0	N/A	15-20

Notes:

Dr James Hampton's costs were recharged by his practice - St Michael's Surgery and the amount recorded as salary includes national insurance and pension contributions paid by the GP practice and recharged to the CCG.
Helen Harris' costs were recharged by her practice - Number 18 Surgery and the amount recorded as salary includes national insurance and pension contributions paid by the GP practice and recharged to the CCG.
The CCG has sought and received assurance regarding the regularity of taxation arrangements for Dr James Hampton and Helen Harris from St Michael's Surgery and Number 18 Surgery respectively.
The requirement to seek such assurance is in line with national guidance.
Mr Myles Taylor's costs were recharged by his host employer - Royal Devon & Exeter NHS Foundation Trust and the amount recorded as salary includes national insurance and pension contributions paid by the Trust and recharged to the CCG.
Lay Members are not eligible for membership of the NHS Pension Scheme so no figures are recorded for pension benefits for John Holden and Suzannah Power
The CCG is unable to disclose pension details for Dr James Hampton, Helen Harris and Mr Myles Taylor due to recharge arrangements.

The costs for Dr Ruth Grabham, Dr Shan Mantri, Dr Elizabeth Hersch, Dr James Hampton, Dr Daisy Curling and Dr Jonathan Osborn include remuneration for work completed for the CCG other than board duties, on commissioning and re-design of clinical services.
Taxable benefits refer to where governing body members are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments.

For comparison the table below shows remuneration for senior managers for 2014/15

NHS Bath and North East Somerset Clinical Commissioning Group - remuneration of senior managers 2014-15

Name and title	From	To	Salary (bands of £5,000)	Expense payments (taxable) to nearest £100	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
			£000	£00	£000	£000
Dr Ian Orpen, Chair of the CCG	01/04/2014	31/03/2015	85 - 90	2	2.5 - 5	90 - 95
Dr Simon Douglass, Clinical Accountable Officer	01/04/2014	30/06/2014	20 - 25	0	10-12.5	30 - 35
Dr Ruth Grabham, Medical Director	01/04/2014	31/03/2015	85 - 90	0	20-22.5	105-110
Tracey Cox, Chief Operating Officer	01/04/2014	30/06/2014	30 - 35	1	72.5 - 75	170 - 175
Tracey Cox, Chief Officer	01/07/2014	31/03/2015	70 - 75	1		
Sarah James, Chief Financial Officer	01/04/2014	31/03/2015	85 - 90	1	0 - 2.5	90 - 95
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	01/04/2014	31/03/2015	85 - 90	2	27.5 - 30	110 - 115
Dr Shan Mantri, GP Cluster Lead	01/04/2014	31/03/2015	25 - 30	0	0 - 2.5	25 - 30
Dr Elizabeth Hersch, GP Cluster Lead	01/04/2014	31/03/2015	25 - 30	0	0 - 2.5	25 - 30
Dr Daisy Curling, GP Cluster Lead	09/10/2014	31/03/2015	10 - 15	0	40 - 42.5	50 -55
Dr Jim Hampton, GP Cluster Lead	01/04/2014	31/03/2015	30 - 35	0	0	30 - 35
Mr Myles Taylor, Secondary Care Representative	01/06/2014	31/03/2015	5 -10	0	0	5 - 10
Helen Harris, Practice Manager Representative	01/04/2014	31/03/2015	10 - 15	0	0	10 - 15
John Holden, Lay Member for Assurance and Governance	01/04/2014	31/03/2015	15 - 20	1	0	15 - 20
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2014	31/03/2015	10 - 15	3	0	10 - 15

Notes:

The CCG was unable to split the pension benefits for Tracey Cox in 2014/15 between her roles as Chief Operating Officer and as Chief Officer, so the pension benefits are shown in total for both roles as is the total including pension benefits.

Dr Jim Hampton's costs were recharged by his practice - St Michael's Surgery and the amount recorded as salary includes national insurance and pension contributions paid by the GP practice and recharged to the CCG.

Helen Harris' costs were recharged by her practice - Number 18 Surgery and the amount recorded as salary includes national insurance and pension contributions paid by the GP practice and recharged to the CCG.

The CCG sought and received assurance regarding the regularity of taxation arrangements for Dr Jim Hampton and Helen Harris from St Michael's Surgery and Number 18 Surgery respectively.

The requirement to seek such assurance is in line with national guidance.

The figures in column E for Sarah James and Dr Shan Mantri were originally calculated as a negative value, i.e. a real terms reduction in pension value. Following audit advice and in line with national guidance, these amounts have been restated and treated as though £Nil and, therefore, moved to the £0 - £2,500 banding.

Mr Myles Taylor's costs were recharged by his host employer - Royal Devon & Exeter NHS Foundation Trust and the amount recorded as salary includes national insurance and pension contributions paid by the Trust and recharged to the CCG.

Lay Members are not eligible for membership of the NHS Pension Scheme so no figures were recorded for pension benefits for John Holden and Suzannah Power

The CCG is unable to disclose pension details for Dr Jim Hampton, Helen Harris and Mr Myles Taylor due to recharge arrangements.

The costs for Dr Ruth Grabham, Dr Shan Mantri, Dr Elizabeth Hersch, Dr Jim Hampton and Dr Daisy Curling included remuneration for work completed for the CCG other than board duties, on

Taxable benefits refer to where governing body members are reimbursed for mileage at a rate above the 45p / mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on

The figures for Dr Ruth Grabham included a payment of c. £4k for work completed in 2013/14, but not paid until early 2014/15. As a result, the figures presented show cash paid during the year, but are slightly higher than the salary actually earned in year.

NHS Bath & North East Somerset Clinical Commissioning Group

Pensions Disclosure - 2015 /16 - Audited

Name and title	(a) Real increase in pension at pension age (bands of £2,500) *£'000*	(b) Real increase in pension lump sum at pension age (bands of £2,500) *£'000*	(c) Total accrued pension at pension age at 31 March 2016 (bands of £5,000) *£'000*	(d) Lump sum at pension age related to accrued pension at 31st March 2016 (bands of £5,000) *£'000*	(e) Cash Equivalent Transfer Value at 1 April 2015 *£'000*	(f) Real increase in Cash Equivalent Transfer Value *£'000*	(g) Cash Equivalent Transfer Value at 31 March 2016 *£'000*	(h) Employer's contribution to stakeholder pension *£'000*
Dr Ian Orpen, Chair of the CCG	0-2.5	2.5-5	10-15	30-35	196	23	221	Nil
Dr Ruth Grabham, Medical Director	0-2.5	2.5-5	15-20	50-55	324	20	347	Nil
Tracey Cox, Chief Officer	2.5-5	5-7.5	35-40	100-105	483	60	549	Nil
Sarah James, Chief Financial Officer	0-2.5	0-2.5	30-35	90-95	548	0	554	Nil
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	0-2.5	2.5-5	15-20	55-60	379	22	405	Nil
Dr Shan Mantri, GP Cluster Lead	0-2.5	2.5-5	10-15	30-35	139	2	142	Nil
Dr Elizabeth Hersch, GP Cluster Lead	0-2.5	0-(2.5)	5-10	20-25	126	4	132	Nil
Dr Daisy Curling, GP Cluster Lead	2.5-5	7.5-10	10-15	30-35	98	39	138	Nil
Dr Jonathan Osborn, GP Cluster Lead	0-2.5	0-2.5	5-10	10-15	55	11	67	Nil

Notes:

Dr James Hampton's pension contributions are paid via his practice - St Michael's Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.

Helen Harris' pension contributions are paid via her practice -Number 18 Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.

Mr Myles Taylor's pension contributions are paid via his host employer - Royal Devon and Exeter NHS Foundation Trust and recharged to the CCG, so the CCG is unable to disclose this detail.

The figures for Dr Ian Orpen, Dr Ruth Grabham, Dr Shan Mantri, Dr Elizabeth Hersch, Dr Jonathan Osborn and Dr Daisy Curling have been calculated based on officer service (work undertaken for the CCG) only and do not take into account any practitioner benefits (work undertaken as a GP).

The government announced in the March 2016 budget that the discount rate for unfunded pension schemes (including the NHS Pension Scheme) would reduce with immediate effect, which will have an effect on factors used in the CETV calculation. As the new CETV factors have not yet been made available, the NHS Pensions Agency have used the existing factors to calculate CETVs. The CCG's external auditors have confirmed that this is a reasonable approach.

For comparison the table below shows pensions for senior managers for 2014/15

NHS Bath & North East Somerset Clinical Commissioning Group

Pensions Disclosure - 2014 / 15

Name and title	(a) Real increase in pension at age 60 (bands of £2,500)	(b) Real increase in pension lump sum at aged 60 (bands of £2,500)	(c) Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	(d) Lump sum at age 60 related to accrued pension at 31st March 2015 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2014	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2015	(h) Employer's contribution to stakeholder pension
	£'000	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*	*£'000*
Dr Ian Orpen, Chair of the CCG	0 - 2.5	2.5 - 5	5 - 10	25 - 30	168	24	196	Nil
Dr Simon Douglass, Clinical Accountable Officer	0 - 2.5	0 - 2.5	15 - 20	45 - 50	267	18	292	Nil
Dr Ruth Grabham, Medical Director	0 - 2.5	2.5 - 5	15 - 20	50 - 55	281	35	324	Nil
Tracey Cox, Chief Operating Officer / Chief Officer	2.5 - 5	10 - 12.5	30 - 35	90 - 95	401	71	483	Nil
Sarah James, Chief Financial Officer	(2.5) - 0	(2.5) - 0	30 - 35	90 - 95	526	7	548	Nil
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	0 - 2.5	5 - 7.5	15 - 20	55 - 60	325	45	379	Nil
Dr Shan Mantri, GP Cluster Lead	0 - 2.5	0 - 2.5	10 - 15	30 - 35	130	5	139	Nil
Dr Elizabeth Hersch, GP Cluster Lead	0 - 2.5	0 - 2.5	5 - 10	20 - 25	116	7	126	Nil
Dr Daisy Curling, GP Cluster Lead	0 - 2.5	5 - 7.5	5 - 10	20 - 25	74	23	98	Nil

Notes:

The CCG was unable to split the pension benefits for Tracey Cox between her roles as Chief Operating Officer and as Chief Officer, so the pension benefits are shown in the above table are for both roles combined.

Dr Jim Hampton's pension contributions were paid via his practice - St Michael's Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.

Helen Harris' pension contributions were paid via her practice -Number 18 Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.

Mr Myles Taylor's pension contributions were paid via his host employer - Royal Devon and Exeter NHS Foundation Trust and recharged to the CCG, so the CCG is unable to disclose this detail.

The figures for Dr Ian Orpen, Dr Simon Douglass, Dr Ruth Grabham, Dr Shan Mantri, Dr Elizabeth Hersch and Dr Daisy Curling have been calculated based on officer service (work undertaken for the CCG) only and do not take into account any practitioner benefits (work undertaken as a GP).

The 2013-14 disclosure showed figures for Dr Ian Orpen and Dr Simon Douglass that included both officer and practitioner benefits. Consequently, the 2013-14 figures used above have been restated by the NHS Pensions Agency to reflect officer service only.

Pensions Benefits (subject to audit)

Certain Board members do not receive pensionable remuneration, therefore there will be no entries in respect of pensions for certain members.

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 pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Payments for loss of office (subject to audit)
During the year no senior managers received a payment for loss of office.

Payments to past senior managers (subject to audit)
During 2015/16 there were no redundancies or other departure costs that have been paid in accordance with the provisions of the NHS Pension Scheme. There were no termination payments or payments made to past senior managers.

Pay multiples (subject to audit)
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director / member in their organisation and the median remuneration of the organisation's workforce

The banded remuneration of the highest paid director / member in NHS Bath and North East Somerset CCG in the financial year 2015-16 was £85,000 - £90,000 (2014-15: £90,000 - £95,000). Based on a whole time equivalent this salary was in the band of £150,000-£155,000 (2014-15: £150,000 - £155,000). This was 3.65

(2014-15: 3.34) times the median remuneration of the remainder of the workforce, which was £41,788 (2014-15: £45,707).

In 2015-16, 0 (2014-15: 0) employees received remuneration in excess of the highest paid director / member in NHS Bath and North East Somerset CCG in whole-time equivalent terms.

Full-time equivalent remuneration ranged from £15,000 to £150,000 (2014-15: £14,000 to £150,000).

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

STAFF REPORT

The CCG currently employs 65 staff comprising 11 men and 54 women (VSM: 0 male (including 0 Board) and three females (including three Board), an overall increase of two from previous year.

Sickness Absence data
Sickness absence data is provided in note 5.3 in the Annual Accounts.

Sickness absence is managed in a supportive and effective manner by CCG managers, with professional advice and support from Human Resources (HR), Occupational Health and staff support services. The CCG's approach to managing sickness absence is governed by a clear HR policy and this is further reinforced by the provision of HR support and training sessions for all line managers on the effective management of sickness absence.

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG on a quarterly basis as part of the workforce reporting mechanism.

Further sickness absence data is provided in note 5.3 in the Annual Accounts.

Staff policies
The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics but it has incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline. Our aim is to operate in ways that do not discriminate against potential or current employees with any of the protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

We monitor our employee profile by each of the nine protected characteristics, this helps us to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

Expenditure on consultancy
Following the publication of the 2014/15 accounts the CCG reviewed the items that were being charged to consultancy and concluded that a number of items were better recorded in the Supplies and Services – General section in Note 5 of the accounts. These items included the charges for the CCG's outsourced contracts for occupational health, payroll, counter fraud and local security management services.

The 2015/16 reported spend is (£10k). A negative expenditure is being reported as costs for consultancy related work accrued for at the 2014/15 year end were later invoiced at a lower amount than expected, leading to a credit of (£12k) in the CCG's

2015/16 accounts. During 2015/16 there was spend of £2k on consultancy services around VAT.

The CCG's external auditor, Grant Thornton, was paid £54,000 (inc. VAT) for Audit Services for the reporting year 2015/16 relating to statutory audit work carried out. These statutory audit services include both the audit of the CCG's financial statements and related reporting, and other statutory activities such as value for money work. Grant Thornton were also paid £360 (inc. VAT) for non-audit related services; these payments were in respect of course fees for CCG staff attending workshops organised by Grant Thornton.

Off payroll disclosure

Under Treasury guidance Public Expenditure System (PES) (2013) 09, all public sector organisations are required to disclose information about high paid off payroll appointments:

a) Off payroll engagements as at 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2016	7
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	3
For between 2 and 3 years at the time of reporting	3

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

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

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	4
Number of new engagements which include contractual clauses giving BaNES CCG the right to request assurance in relation to income tax and National Insurance obligations	4
Number for whom assurance has been requested	4
Of which:	

assurance has been received	4
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

The figures declared in the table above include two assignments that were overlooked in previous submissions. These are reported in table 1 for the relevant length of assignment, but are classed as new engagements in table2 as this is the first financial year where the CCG has sought (and received) the contractual assurance.

c) For any off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2015 and 31 March 2016.

Number of off-payroll engagements of board members and / or senior officers with significant financial responsibility, during the year	2
Number of individuals that have been deemed "board members, and / or senior officers with significant financial responsibility" during the financial year.	15

The two Board members who were paid through off payroll arrangements are Dr James Hampton and Helen Harris who are paid via their GP practice's payroll (St Michael's Surgery and Number 18 Surgery respectively) and recharged to the CCG. The CCG has sought and received assurance from each of the practices that the appropriate deductions are being made for tax and National Insurance contributions.

Exit Packages (subject to audit)
During 2015/16 there were no redundancies or other departure costs that have been paid in accordance with the provisions of the NHS Pension Scheme. There were no termination payments or payments made to past senior managers.

Signed : **Date:**

Sarah James
Deputy Accountable Officer
Signed for and on behalf of Accountable Officer

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS Bath and North East Somerset Clinical Commissioning Group **(Draft)**

We have audited the financial statements of Bath and North East Somerset CCG 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).

This report is made solely to the members of the Governing Body of Bath and North East Somerset CCG , 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 and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified 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 Bath and North East Somerset CCG 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 Bath and North East Somerset CCG in accordance with the requirements of the Act and the Code of Audit Practice.

Peter A Barber

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

Hartwell House

Victoria Street

Bristol BS1 6FT

26 May 2016

All documents that are referenced as appearing on the BaNES CCG website can be found using the 'Search the CCG website' function at the top of our homepage. To access the website, visit www.bathandnortheastsomersetccg.nhs.uk.

Section 3: FINANCIAL REPORT

Annual Accounts 2015/16

CONTENTS **Page Number**

The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended

31-March-2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	5	3,249	2,672
Operating Expenses	6	223,477	215,235
Other operating revenue	3	(1,930)	(1,734)
Net operating expenditure before interest		**224,796**	216,173
Investment Revenue and Costs		0	0
Net operating expenditure for the financial year		**224,796**	216,173
Total Net Expenditure for the year		**224,796**	216,173
Of which:			
Administration Income and Expenditure			
Employee benefits	5	2,415	2,051
Operating Expenses	6	1,709	2,247
Other operating revenue	3	(407)	(265)
Net administration costs before interest		**3,717**	4,033
Programme Income and Expenditure			
Employee benefits	5	834	621
Operating Expenses	6	221,768	212,988
Other operating revenue	3	(1,523)	(1,469)
Net programme expenditure before interest		**221,079**	212,140
Other Comprehensive Net Expenditure		0	0
Total comprehensive net expenditure for the year		**224,796**	216,173

The notes on pages 5 to 18 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Total non-current assets		**0**	0
Current assets:			
Trade and other receivables	9	856	1,933
Cash and cash equivalents	10	197	104
Total current assets		**1,053**	2,037
Total assets		**1,053**	2,037
Current liabilities			
Trade and other payables	11	(11,973)	(12,986)
Provisions	12	0	(218)
Total current liabilities		**(11,973)**	(13,204)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(10,920)**	(11,167)
Total non-current liabilities		**0**	0
Assets less Liabilities		**(10,920)**	(11,167)
Financed by Taxpayers' Equity			
General fund		(10,920)	(11,167)
Total taxpayers' equity:		**(10,920)**	(11,167)

The notes on pages 5 to 18 form part of this statement

The financial statements on pages 1 to 18 were approved by the Governing Body on 26th May 2016 and signed on its behalf by:

Signed **Date**

Sarah James
Deputy Accountable Officer
Signed for and on behalf of Accountable 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	**(11,167)**	**0**	**0**	**(11,167)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(224,796)			(224,796)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(235,963)**	**0**	**0**	**(235,963)**
Net funding	225,043	0	0	225,043
Balance at 31 March 2016	**(10,920)**	**0**	**0**	**(10,920)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(8,608)**	**0**	**0**	**(8,608)**
Changes in NHS Commissioning Board taxpayers' equity for 2014-15				
Net operating costs for the financial year	(216,173)	0	0	(216,173)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(224,781)**	**0**	**0**	**(224,781)**
Net funding	213,613	0	0	213,613
Balance at 31 March 2015	**(11,167)**	**0**	**0**	**(11,167)**

The notes on pages 5 to 18 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		(224,796)	(216,173)
Decrease in trade & other receivables	9	1,077	(277)
Decrease in trade & other payables	11	(1,013)	3,154
Provisions utilised	12	0	(114)
Decrease in provisions	12	(218)	(11)
Net Cash Outflow from Operating Activities		**(224,950)**	(213,421)
Net Cash Outflow from Investing Activities		**0**	0
Net Cash Outflow before Financing		**(224,950)**	(213,421)
Cash Flows from Financing Activities			
Parliamentary Funding Received		225,043	213,613
Net Cash Inflow from Financing Activities		**225,043**	213,613
Net Increase in Cash & Cash Equivalents	10	**93**	192
Cash & Cash Equivalents at the Beginning of the Financial Year		**104**	(88)
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		**197**	104

The notes on pages 5 to 18 form part of this statement

1 Notes to the financial statements

1.0 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention.

1.3 Pooled Budgets

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

- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group's share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a "jointly controlled assets" arrangement, in addition to the above, the Clinical Commissioning Group recognises:

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

1.4 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.

1.4.1 Critical Judgements in Applying Accounting Policies

There are no critical judgements, apart from those involving estimations (see below) that management have 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.

1.4.2 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:

The Clinical Commissioning Group has been unable to agree a final expenditure figure with the Royal United Hospital NHS Foundation Trust (RUH). The accounts contain accruals which are £409k lower than those included in the accounts of the RUH as it does not believe that under the terms of the SLA this amount is due.

1.5 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.

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

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

1.6.2 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.

1.7 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.

1.8 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. In the current year the Clinical Commissioning Group only holds operating leases.

1.8.1 The Clinical Commissioning Group as Lessee

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.

1.8.2 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.

1.9 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.

1.10 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. All obligations are expected to be settled in the following financial year.

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.

The Clinical Commissioning Group has made no provisions in the 2015-16 accounts.

1.11 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.

Currently the Clinical Commissioning Group has no clinical negligence claims outstanding.

1.12 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.

1.13 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.

1.14 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.

The Clinical Commissioning Group has not included any contingencies in the 2015-16 accounts.

1.15 Financial Assets

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

The Clinical Commissioning Group has included receivables and cash or cash equivalents in the accounts which have been recognised at historic cost.

1.16 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.

The Clinical Commissioning Group has included only payables in the 2015-16 accounts which have been recognised at historic cost.

1.17 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.

1.18 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.

1.19 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).

The Clinical Commissioning Group has not made any losses or special payments in 2015-16.

1.20 **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 Financial performance targets

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

Bath & North East Somerset Clinical Commissioning Group performance against those duties was as follows:

	2015-16 Target	**2015-16 Performance**	2014-15 Target	2014-15 Performance
Expenditure not to exceed income	**228,973**	**226,726**	221,592	217,907
Revenue resource use does not exceed the amount specified in Directions	**227,043**	**224,796**	219,858	216,173
Revenue administration resource use does not exceed the amount specified in Directions	**4,707**	**3,717**	5,005	4,033

3 Other Operating Revenue

Other Operating Revenue

	2015-16 Total	**2015-16 Admin**	**2015-16 Programme**	2014-15 Total
	£000	**£000**	**£000**	£000
Recoveries in respect of employee benefits	**254**	254	0	99
Prescription fees and charges	**30**	0	30	9
Charitable and other contributions to revenue expenditure: non-NHS	**15**	0	15	15
Non-patient care services to other bodies - *Note 1*	**970**	76	894	1,355
Other revenue	661	77	584	255
Total other operating revenue	**1,930**	**407**	**1,523**	**1,734**

Notes:

Note 1 - The 2014-15 figure for Non Patient Care included a one off receipt (£313k) from BaNES Council relating to an underspend from previous years refunded in that year. It also included £89k of non-recurrent project funding from NHS England.

4 Revenue

	2015-16 Total	**2015-16 Admin**	**2015-16 Programme**	2014-15 Total
	£000	**£000**	**£000**	£000
From rendering of services	**1,930**	407	1,523	1,734
From sale of goods	**0**	0	0	0
Total	**1,930**	**407**	**1,523**	**1,734**

5 Employee benefits and staff numbers

5.1.1 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	**2,709**	2,320	389	**2,014**	1,711	303	**695**	609	86
Social security costs	**204**	201	3	**152**	152	(0)	**52**	49	3
Employer Contributions to NHS Pension scheme	**336**	316	20	**249**	233	16	**87**	83	4
Gross employee benefits expenditure	**3,249**	**2,837**	**412**	**2,415**	**2,096**	**319**	**834**	**741**	**93**
Less recoveries in respect of employee benefits (note 5.1.2)	**(254)**	(254)	0	**(254)**	(254)	0	**0**	0	0
Total - Net admin employee benefits including capitalised costs	**2,995**	**2,583**	**412**	**2,161**	**1,842**	**319**	**834**	**741**	**93**
Less: Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Net employee benefits excluding capitalised costs	**2,995**	**2,583**	**412**	**2,161**	**1,842**	**319**	**834**	**741**	**93**

5.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	**2,218**	1,837	381	**1,692**	1,403	290	**526**	435	91
Social security costs	**189**	169	20	**154**	134	20	**35**	35	0
Employer Contributions to NHS Pension scheme	**264**	248	16	**204**	188	16	**60**	60	0
Gross employee benefits expenditure	**2,672**	**2,254**	**418**	**2,051**	**1,724**	**327**	**621**	**530**	**91**
Less recoveries in respect of employee benefits (note 5.1.2)	**(99)**	(99)	0	**(99)**	(99)	0	**0**	0	0
Total - Net admin employee benefits including capitalised costs	**2,572**	**2,155**	**418**	**1,951**	**1,625**	**327**	**621**	**530**	**91**
Less: Employee costs capitalised	**0**	0	0	**0**	0	0	**0**	0	0
Net employee benefits excluding capitalised costs	**2,572**	**2,155**	**418**	**1,951**	**1,625**	**327**	**621**	**530**	**91**

5.1.2 Recoveries in respect of employee benefits

2015-16	Total £000	Permanent Employees £000	Other £000	2014-15 Total £000
Employee Benefits - Revenue				
Salaries and wages	**(205)**	(205)	0	(80)
Social security costs	**(20)**	(20)	0	(8)
Employer contributions to the NHS Pension Scheme	**(29)**	(29)	0	(11)
Total recoveries in respect of employee benefits	**(254)**	**(254)**	**0**	**(99)**

Note - The above table shows a significant increase in staff costs from 2014-15. This is as a result of the transfer in house of staff and services formerly provided by NHS Central Southern CSU on the 1st October 2014.

5.2 Average number of people employed

	2015-16			2014-15
	Total Number	**Permanently Employed Number**	**Other Number**	Total Number
Total	**57**	51	6	47

There are no people engaged on capital projects in either 2014-15 or 2015-16

5.3 Staff sickness absence and ill health retirements

	2015-16 Number	**2014-15 Number**
Total Days Lost	294	17
Total Staff Years	50	33
Average working Days Lost	**6**	**1**

The figure quoted for average working days lost in 2014-15 was the nationally mandated figure although our locally calculated figure suggested this should have been 3 working days lost.
No employees retired early on ill health grounds
Any ill health retirement costs are met by the NHS Pension Scheme
No additional pensions liabilities were accrued in year

5.4 Exit packages agreed in the financial year

The Clinical Commissioning Group has not agreed any exit packages in 2015-16

5.5 Pension costs

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

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

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

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

5.5.1 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 £328,469 were payable to the NHS Pensions Scheme (2014-15: £267,208) at the rate of 14.3% (2014-15: 14%) of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the staff costs line of note 6.

6 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 - *Note 1*	**2,876**	2,042	834	2,196
Executive governing body members	**373**	373	0	476
Total gross employee benefits	**3,249**	**2,415**	**834**	**2,672**
Other costs				
Services from other CCGs and NHS England - *Note 1*	**1,629**	1,219	410	2,178
Services from foundation trusts - *Note 2*	**99,058**	0	99,058	56,296
Services from other NHS trusts - *Note 2*	**22,712**	0	22,712	62,777
Services from other NHS bodies	**3**	0	3	77
Purchase of healthcare from non-NHS bodies - *Note 3*	**70,420**	0	70,420	63,928
Chair and Non-Executive Members	**149**	149	0	213
Supplies and services – clinical	**835**	0	835	1,247
Supplies and services – general	**130**	26	104	280
Consultancy services	**(10)**	(10)	0	158
Establishment	**188**	116	72	332
Transport	**3**	3	0	1
Premises - *Note 4*	**8**	90	(82)	558
Audit fees	**54**	54	0	72
General dental services and personal dental services	**0**	0	0	2
Prescribing costs	**25,509**	0	25,509	24,092
General ophthalmic services	**8**	0	8	9
GPMS/APMS and PCTMS	**1,925**	0	1,925	1,776
Other professional fees excl. audit	**49**	37	12	54
Grants to other public bodies	**473**	0	473	717
Clinical negligence	**5**	5	0	5
Research and development (excluding staff costs)	**22**	0	22	79
Education and training	**20**	19	1	83
Provisions	**(218)**	0	(218)	(11)
CHC Risk Pool contributions	**504**	0	504	311
Total other costs	**223,476**	**1,708**	**221,768**	**215,235**
Total operating expenses	**226,725**	**4,123**	**222,602**	**217,907**

Notes:

Note 1 - The movement in expenditure is as a result of the full year effect of the transfer in house of services formerly provided by NHS Central Southern CSU on the 1st October 2014 in the 2015-16 accounts.

Note 2 - The primary cause of the increase in Services from Foundation Trusts and a corresponding decrease in Services from NHS Trusts is the full year effect of the Royal United Hospital's change of status part which occurred part way through 2014-15.

Note 3 - £6.4m (9%) of the increase in expenditure for purchase of healthcare from non-HNS bodies relates to the introduction of the Better Care Fund which is hosted by BaNES council. Further details are disclosed in note 15.

Note 4 - The reduction in premises from 2014-15 (£558k) to 2015-16 (£8k) is as a result of the receipt in year of a rebate on community hospitals and health centers owned by NHS Property Services Ltd (£66k) in place of last year's charge. Full details are disclosed in note 8.1.1.

7 Better Payment Practice Code

7.1

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	3,928	86,334	2,917	50,060
Total Non-NHS Trade Invoices paid within target	3,741	85,029	2,773	49,213
Percentage of Non-NHS Trade invoices paid within target	**95.24%**	**98.49%**	95.06%	98.31%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,486	116,828	2,314	123,270
Total NHS Trade Invoices Paid within target	2,406	114,878	2,261	121,874
Percentage of NHS Trade Invoices paid within target	**96.78%**	**98.33%**	97.71%	98.87%

7.2 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

8 Operating Leases

8.1 As lessee

The Clinical Commissioning Group occupies and pays rent on its office accommodation at St Martins Hospital. They also pay rent in respect of vacant space at Riverside Health Centre. The properties are owned by NHS Property Services Ltd. There are no contracts currently in place even though the nature of the transaction conveys the right for the Clinical Commissioning Group to use the property. Under paragraph 9 of IFRIC 4 these arrangements are a lease and as such are accounted for in accordance with IAS 17. Payments in respect of this arrangement for 2015-16 are disclosed below:

8.1.1 Payments recognised as an Expense

The negative figure for buildings has arisen as a result of the National arrangements around Commissioners subsidising providers, where the provider does not pay the full cost of their occupancy to NHS Property services Ltd. In previous years the Clinical Commissioning Group has incurred a cost associated with these subsidies however in 2015-16 the costs of running the properties has decreased and a number of vacant properties have been disposed of by NHS Property Services Ltd reducing the costs to the point where the Clinical Commissioning Group received a rebate.

			2015-16			2014-15
	Buildings £000	**Other £000**	**Total £000**	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	(66)	2	**(64)**	550	2	552
Contingent rents	0	0	**0**	0	0	0
Sub-lease payments	0	0	**0**	0	0	0
Total	**(66)**	**2**	**(64)**	550	2	552

8.1.2 Future minimum lease payments

Whilst our arrangements with 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.

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

8.2 As lessor

The CCG has no operating leases as a lessor to report in 2015-16.

9 Trade and other receivables

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	**263**	**0**	926	0
NHS prepayments	**69**	**0**	53	0
NHS accrued income - *Note 1*	**352**	**0**	0	0
Non-NHS receivables: Revenue	**57**	**0**	886	0
Non-NHS prepayments	**98**	**0**	38	0
Non-NHS accrued income	**13**	**0**	0	0
VAT	**4**	**0**	30	0
Total Trade & other receivables	**856**	**0**	**1,933**	**0**
Total current and non-current	**856**		**1,933**	

There are no prepaid Pension Contributions in the above receivables figures

Notes

Note 1 - £348k of the current year figure relates to underperformance by North Bristol NHS Trust calculated at the year end and owed to the Clinical Commissioning Group.

9.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	10	11
By three to six months	0	15
Total	**10**	**26**

The £10k remains outstanding post the statement of financial position date. The Clinical Commissioning Group continues to pursue the debts and remain confident of their recovery.

The Clinical Commissioning Group does not hold any collateral against outstanding receivables at 31 March 2016 and has made no provision for impairment of receivables in 2015-16.

10 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	**104**	(88)
Net change in year	**93**	192
Balance at 31-March-2016	**197**	**104**
Made up of:		
Cash with the Government Banking Service	**197**	104
Balance at 31-March-2016	**197**	**104**

The Clinical Commissioning Group does not hold any patients' monies

11 Trade and other payables

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	2,792	0	1,705	0
NHS accruals	562	0	1,778	0
NHS deferred income	16	0	0	0
Non-NHS payables: revenue	2,913	0	2,694	0
Non-NHS accruals	5,521	0	6,651	0
Non-NHS deferred income	7	0	0	0
Social security costs	32	0	29	0
Tax	33	0	33	0
Other payables	97	0	96	0
Total Trade & Other Payables	**11,973**	**0**	**12,986**	**0**
Total current and non-current	**11,973**		**12,986**	

Other payables include £49k of outstanding pension contributions at 31 March 2016

12 Provisions

Provisions	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Continuing care	0	0	218	0
Total	**0**	**0**	218	0
Total current and non-current	**0**	**0**	218	0

	Continuing Care £000s	**Other £000s**	**Total £000s**
Balance at 01-April-2015	**218**	**0**	**218**
Arising during the year	0	0	**0**
Utilised during the year	0	0	**0**
Reversed unused	(218)	0	**(218)**
Balance at 31-March-2016	**0**	**0**	**0**

13 Other financial commitments

The Clinical Commissioning Group has not entered into any non-cancellable contracts.

14 Financial instruments

14.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the 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.

14.1.1 Currency risk

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

14.1.2 Interest rate risk

The Clinical Commissioning Group does not undertake capital expenditure, and therefore has no exposure to interest rate fluctuations.

14.1.3 Credit risk

Because the majority of the Clinical Commissioning Group and revenue comes parliamentary funding, 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.

14.1.4 Liquidity risk

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

Financial instruments cont'd

14.2 Financial assets	**Loans and Receivables 2015-16 £000**	**Total 2015-16 £000**
Receivables:		
· NHS	615	**615**
· Non-NHS	70	**70**
Cash at bank and in hand	197	**197**
Total at 31-March-2016	882	882

	Loans and Receivables 2014-15 £000	Total 2014-15 £000
Receivables:		
· NHS	926	926
· Non-NHS	886	886
Cash at bank and in hand	104	104
Total at 31-March-2015	1,916	1,916

14.3 Financial liabilities	**Other 2015-16 £000**	**Total 2015-16 £000**
Payables:		
· NHS	3,354	**3,354**
· Non-NHS	8,532	**8,532**
Total at 31-March-2016	**11,886**	**11,886**

	Other 2014-15 £000	Total 2014-15 £000
Payables:		
· NHS	3,483	3,483
· Non-NHS	9,441	9,441
Total at 31-March-2015	**12,924**	**12,924**

14 Operating Segments

The Clinical Commissioning Group considers it has only one operating segment, namely the commissioning of healthcare services.

15 Pooled budgets

The Clinical Commissioning Group has entered into Pooled Budget arrangements with Bath and North East Somerset Council. The pools are hosted by Bath and North East Somerset Council.

Funds are pooled under Section 75 of the NHS Act 2006 for Adult Learning Disability and Community Equipment also Section 10 of the Children's Act 2004 for Children and Young People with Multiple and Complex Needs.

The audited memorandum accounts for the Pooled Budgets are:	**Total**	Community Equipment	Children and Young People with Multiple and Complex Needs	Adult Learning Disability *- Note 1*	Better Care Fund *- Note 2*	Mental Health
	£000	£000	£000	£000	£000	£000
Gross Funding						
Bath & North East Somerset Council	**28,697**	202	2,571	21,249	1,148	3,527
Bath & North East Somerset Clinical Commissioning Group	**15,792**	473	392	3,554	8,475	2,898
Income from client contributions	**1,746**	0	0	1,746	0	0
Interest on External Funding Balances	**21**	1	0	20	0	0
Total Funding	**46,256**	676	2,963	26,569	9,623	6,425
Net underspend repaid as detailed below						
Bath & North East Somerset Council	**265**	0	113	152	0	0
Bath & North East Somerset Clinical Commissioning Group	**64**	0	18	46	0	0
Total Underspend	**329**	0	131	198	0	0

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs was signed on 18 April 2016 and all the other accounts were signed on 21 April 2016 by the Chief Financial Officer of Bath & North East Somerset Council.

These statements confirm that the Memorandum Accounts accurately disclose the income received and expenditure incurred in accordance with the Partnership Agreement, as amended by subsequent agreed variations, entered into under section 75 of the NHS Act of 2006.

The 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	329	29,028
Expenditure	(46,256)	(28,609)

Notes:

Note 1 - The accruals in the accounts were estimated prior to the issue of the memorandum accounts shown above and differ to the above by £12k on the Children's pooled budget. This will appear as a cost in 2016-17 accounts.

16 Related party transactions

Details of related party transactions with individuals are as follows:

		Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Newbridge Surgery	Dr Ruth Grabham	137	0	0	0
Newbridge Surgery	Dr Shan Mantri	137	0	0	0
St Chad's Surgery	Dr Elizabeth Hersch	584	0	0	0
St James Surgery	Ian Orpen	147	0	0	0
Combe Down Surgery	Dr Jonathan Osborn	131	0	0	0
St Michaels Surgery	Dr James Hampton	134	0	0	0
BaNES Enhanced Medical Services +	Dr James Hampton	1,535	5	90	0

The Clinical Commissioning Group has made payments for local enhanced service SLA's and dispensing drugs to GP practices of which members of the Governing Body are partners. These payments have been made to an organisation and not to the individuals.

Dr James Hampton was for the majority of the year a Board Member of BaNES Enhanced Medical Services +.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with the entities named below for which the Department is regarded as the parent organisation.

NHS England
NHS Business Services Authority
NHS Litigation Authority
Avon and Wiltshire Mental Health Partnership NHST
North Bristol NHST
Oxford Health NHS Foundation Trust
Royal United Hospital Bath NHSFT
South West Ambulance NHSFT
University Hospital Bristol NHSFT

In addition, the Clinical Commissioning Group had a number of material transactions with other Government departments and other central and local Government bodies. Most of these transactions have been with Bath & North East Somerset Council.

18 Events after the end of the reporting period

There are no events after the end of the reporting period which will have a material effect on the financial statements of the Clinical Commissioning Group.

19 Losses and special payments

The Clinical Commissioning Group has no losses and special payments cases to report in 2015-16.