NHS
Bath and
North East Somerset
Clinical Commissioning Group

Annual Report and Accounts 2016/17

Contents

Performance Report……3
Section 1: Performance Overview……4
Chief Officer and Chair's statement……5
About us.....……..7
Summary of our performance: Service updates……13

Section 2: Performance Analysis……21
How we measure our performance……21
Sustainability report……31
Financial review……..39

Accountability Report……...45
Corporate Governance Report……...46
Statement of Accountable Officer's Responsibilities……..57
Governance Statement……59
Risk management arrangements and effectiveness……..75
Remuneration report……86
Staff report……93

The accounts in this report have been prepared in accordance with the Department of Health Group Accounting Manual and relevant directions from NHS England.

This report can be made available in large print and in other languages by request to:

NHS Bath and North East Somerset Clinical Commissioning Group
St Martins Hospital
Clara Cross Lane
Bath
BA2 5RP

Phone: 01225 831800

Email: BSCCG.information@nhs.net

Section 1
Performance Report

Signed:

Tracey Cox
Accountable Officer
25 May 2017

Performance Overview

Overview

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 26 surgeries within B&NES. Our geographical boundary matches that of Bath and North East Somerset (B&NES) Council.

The number of patients registered with GP practices in B&NES is higher than the resident population, at 199,660 patients (March 2014) versus 184,874 residents. In 2016/17 our budget was £233.65 million.

This Performance Overview will explain the purpose and function of the CCG, our objectives and the risks to achieving those objectives, and how we have performed during the year 2016/17 with reference to the services we commission.

Chief Officer and Chair's Foreword

Welcome to the annual report and accounts for Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) 2016/17. This is our fourth annual report covering all the work we do to develop, commission and monitor high-quality services for everyone in Bath and North East Somerset (B&NES).

This has been both our most challenging and our most productive year as a commissioning organisation. The challenges have arisen from the rising pressure on our budget caused by the increasing demand for health and care services and these financial pressures are set to continue into future years.

Yet 2016/17 has also been very productive for the CCG. It is imperative that we innovate and transform models of care so our services are high quality and sustainable in the longer term. We have already seen a number of successes with this approach.

Notably, we completed our two-year review of community services; your care, your way with the Council and these services transferred to the prime provider Virgin Care on 1 April. This marks an important step towards achieving our vision of a new model of community services that empowers everyone to live happier, healthier lives and places people at the heart of services. A vision developed jointly with local people and our partner organisations.

We cannot deliver more services in the community without the support of primary care. So in the past year we have encouraged our GP practices to begin working more closely together. This will help to ensure financial sustainability, broaden the range of services practices offer and improve access for their patients at evenings, weekends and online. Our emerging primary care strategy and effective collaboration with practices helped us to secure nearly £4 million in additional funding to support improvements to our GP infrastructure, digital communications and telephony.

The your care your way review has helped shape our view of how we can plan and deliver services for our population across the local health and care system. The past year has also seen us strengthening our relationships, not only with the Council, but with health and care partners in B&NES, Swindon and Wiltshire as part of our Sustainability and Transformation Plan (STP). We are playing an instrumental role within this partnership as members of the STP Leadership group and by leading on specific areas of work in B&NES such as preventative care and mental health services. We will continue to collaborate with our STP partners to set out how we are responding together to NHS England's Five Year Forward View and 'Next Steps.'

We know that difficult times lie ahead, but in line with our values and ethos, we understand that we can only ensure high-quality services for local people and achieve sustainability through working collaboratively with patients, carers, partner organisations and our staff.

Tracey Cox
Chief Officer

Dr Ian Orpen
CCG Clinical Chair

About Us

BaNES CCG is the NHS organisation that monitors and coordinates the delivery of health services on behalf of everyone living in B&NES.

We are one of 204 CCGs (originally there were 211 CCGs) that were authorised and established by NHS England in April 2013 after the Health and Social Care Act 2012 was passed. We are an independent statutory body governed by members of the 26 GP practices across Bath and North East Somerset. This is our fourth year of operation.

The range of services we oversee and commission is broad and includes planned hospital care, acute and urgent hospital care and most community health services including children's health, mental health and learning disabilities services.

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 (SWASFT)
- Care UK which provides NHS111 services
- Banes 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. This year has seen us working particularly closely with Swindon and Wiltshire CCGs as we make progress with our joint Sustainability and Transformation Plan.

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
- 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.

Our population

There are 184,874 residents in B&NES. There is a significantly higher proportion of residents aged 20-24 years than nationally at 11 per cent compared with 7 per cent, which can be attributed to the high student population.

Population density varies across areas locally, ranging from 51 people per square kilometre in Corston to nearly 10,000 for Oldfield Park West in Bath.

Our area 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 identify themselves as White Other and 1 per cent who identify themselves as Chinese.

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

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, compared with 2012.

These changes are already increasing demand on NHS and social care services.

Significant health factors

Whilst life expectancy is higher than the regional and national averages, someone living in the most deprived area of B&NES can expect to die at a younger age than someone in the most affluent area (9.2 years earlier for men and 5.2 years for women).

Although the people of B&NES are relatively healthy, there are avoidable differences in health factors between different sections of our population. For example, the obesity rate among 10-11 year-olds in the most deprived areas of B&NES is almost twice that compared with those in the least deprived.

Key issues and risks

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:

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 inability to meet some of the NHS constitutional targets in 2016/17, including the A&E four-hour waiting time targets at our main provider, the RUH.

We continue to work with all of our providers to resolve the issues that are impacting on the whole health system's ability to deliver these constitutional standards.

Quality, safety and experience of care: we aim to ensure that the quality of health and care services is constantly improving. That patients', service users and their families and carers' experience of this care is good and that services are delivered safely and effectively. This is all in the context of working within our financial allocation and managing the ever-increasing demand for services.

Finance: 2016/17 has seen us facing our toughest financial challenges yet as a CCG. We have regularly reported the rising pressure on our budget caused by the increasing demand for health and care services and we have made considerable efforts over the last twelve months to reduce our expenditure.

We are reviewing services which are a lower priority and where the funding could be reallocated to treat more patients more effectively. For example, we have changed our prescribing policy for gluten-free and some over-the-counter products (e.g. painkillers where they are used to treat minor ailments). From April 2017 these products are now no longer available on prescription except to the most vulnerable patients.

Whilst we achieved a balanced financial position by the end of 2016/17, we were not able to deliver the one per cent surplus of £2.3m as required of us by NHS England. The nationally mandated treatment of the 1% headroom has the effect of making the CCG's underlying financial position appear to be better than it is. It is this underlying position which accounts for the financial challenges we face in 2017/18 and beyond.

The CCG's financial pressures are set to continue into future years. If we do not make further reductions in our spend on services, the funding gap will continue to increase as demand and costs rise further above our allocated budget.

We are developing a plan to deliver the significant savings required, balancing this with our determination to minimise the adverse impact on patients.

The success of this plan will require greater levels of partnership working with local health and care organisations and our GP members. We will also work with our wider stakeholders and patients to identify how we can commission services appropriately to continue providing high quality health services for our local population.

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 learning disabilities and specialist mental health budgets. To strengthen joint working across the CCG and the Council, a number of commissioning and other staff 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 December 2016, we held a joint event for Council and CCG staff to reflect on our achievements as well as our plans for the future. We heard from a local GP who works with patients who have particularly challenging health issues and reflected on the impact of inequalities across the region. Also Virgin Care's Regional Director of Operations for the South West –Jayne Carroll – outlined the vision and priorities for the future delivery of community health and care services in B&NES.

The CCG Ipsos Mori 360 stakeholder survey helps us to monitor that we have good relationships in place. Results in 2016 demonstrated that we are in line with other CCGs on many indicators but above average in a couple of key areas. For example, 85 per cent of respondents rated their working relationship with the CCG as good, 90

per cent feel able to raise concerns about the quality of services with the CCG and 85 per cent know about the CCG's plans and priorities.

However, there are a number of areas to address; only 55 per cent of respondents say the clinical leadership is delivering continued quality improvements and only 48 per cent believe that the CCG takes on board suggestions for improvement. Our GP members in particular indicated some dissatisfaction with the CCG. We are responding by developing and implementing a communications strategy for primary care that seeks to improve engagement via our regular GP Forum meetings and e-communication channels.

Sustainability and Transformation Plan (STP)

In November 2016, we published our emerging plans as a Sustainability and Transformation Partnership across B&NES, Swindon and Wiltshire. The complexities of our local health and care network and our location means that we are already working across regional boundaries, where appropriate, to plan services. But in the last year we have begun working even more closely with colleagues at B&NES Council and our neighbouring CCGs and local authorities as well as health and care providers to build a fully integrated, collaborative health and care system. In partnership, we will pursue the triple aim of improving the experience of care, improving the health of our population and ensuring cost-effective and sustainable services.

Our STP has five key priorities:

1. Create locality-based integrated teams supporting primary care
2. Shift the focus of care from treatment to prevention and proactive care
3. Develop efficient infrastructure to support new care models
4. A flexible and collaborative approach to workforce
5. Enable better collaboration between the three acute hospitals across our combined region.

More information can be found at www.bswstp.nhs.uk.

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 in B&NES to live happier and healthier lives.

How we engage with staff
We conducted our annual staff survey in February 2017 and just over three-quarters (76 per cent) of staff responded, which is higher than in previous surveys. Just over 81 per cent of those who responded said they felt that the CCG communicates

effectively with them, with the same number reporting that they find our monthly staff briefings useful.

We also communicate daily with staff via the CCG intranet, which was overhauled in 2015 following feedback from the staff survey. During summer 2016 we reviewed its use with all CCG teams, some of which have chosen to host their 'own' pages on the intranet in order to make cross-team comm6.unication easier as well as share resources. One particular example of this is the Programme Management Office intranet 'Space', which houses forms and templates relating to project management.

In 2016 we began holding monthly staff 'Lunch and Learn' sessions involving a range of topics from how to become a CCG social media champion, to what the national Time to Change campaign means for mental health.

Wellbeing Group

The CCG's Wellbeing Group meets every quarter to discuss ways to improve staff wellbeing and create a better office environment. Results from the latest staff survey show that an overwhelming majority of staff (83 per cent) feel that the CCG takes positive action on health and wellbeing.

In summer 2016, the Wellbeing Group enrolled CCG staff into the Global Corporate Challenge and 98 CCG and joint Council colleagues competed with each other and teams all over the world to see who could 'step the furthest' in 100 days. The Challenge also suggested ways to improve wellbeing, sleep, nutrition and concentration.

Feedback after the Challenge was very positive and the Wellbeing Group have enrolled staff to take part in it again in summer 2017. The group are also supporting mental health training for CCG staff during 2017.

NHS staff are encouraged to have a flu jab each year as winter approaches to help protect them from getting flu and to avoid its spread to colleagues and patients. During winter 2016, the uptake for BaNES CCG staff was 77 per cent. This exceeds the national target of 75 per cent set for NHS organisations.

Training and development

The recent staff survey showed that more than half of respondents feel encouraged to develop their skills and abilities and feel confident they will receive the right training and opportunities to be able to perform their best.

Staff have taken advantage of various in-house and external opportunities through the year, including sessions run by our Commissioning Support Unit on how to manage change and the skills needed for an effective team.

Summary of our performance: Service updates

1. Community services

Our two-year review of community health and care services with B&NES Council 'your care, your way' was completed this year with the appointment of Virgin Care as our new prime provider.

Following an extensive programme of engagement and consultation with local people and professionals in 2015/16, we began a procurement process in February 2016 to select the organisation most capable of delivering the community's priorities.

We recruited and trained a team of community champions to work alongside subject matter experts from the CCG and the Council during the procurement process. The champions all have direct experience of community services as service users or carers so they understand what needs to change and what would make a real difference to their lives.

The Full Business Case was presented to the CCG Board and to Council members at separate meetings on 10 November 2016. Following rigorous debate, both organisations approved the contract award to Virgin Care.

Following the decision, a considerable amount of work took place to ensure the safe transfer of services from Sirona care & health to Virgin Care on 1 April 2017. A Safe Transfer Group was set up to oversee this mobilisation phase consisting of commissioning, finance, HR, IT and communications leads from Virgin Care, the CCG and the Council. This group was supported by a number of separate work streams as well as strategic guidance from a steering group of senior managers.

Communication with the professionals who were transferring across to Virgin Care was the key priority during this phase. Any questions were answered on a weekly basis on the Sirona intranet to ensure that staff had all the information and resources they need to minimise any disruption to services. More information is available at www.yourcareyourway.org.

2. Transforming primary care

In May 2016, we published our Draft Statement of Intent for Primary Care, setting out our vision for general practice by 2020. Our statement came just after the publication of NHS England's GP Forward View which sets out a raft of national measures and investment for general practice.

Our statement of intent encourages practices to work together more closely to ensure financial sustainability, broaden the range of services they offer and improve access for their patients at evenings, weekends and online. The strategy is closely

aligned with Virgin Care's model for community health and care services, which will be organised around clusters of GP practices.

In July 2016, St James's Surgery and Catherine Cottage Surgery in Bath merged to become one GP practice. NHS England and the CCG supported the merger, which gives patients greater access to GPs, nurses and other primary care services in modern healthcare premises.

GP practices in B&NES scored highest in the country for patient experience in the most recent GP Patient Survey. The results show that 94 per cent of B&NES patients describe their experience at their GP surgery as 'good', compared with a national average of 85 per cent.

The number of B&NES patients aware of the online services offered at their GP practice is still low however, at 37 per cent. Indeed, figures from February 2016 show that eight practices in B&NES still have less than 10 per cent of patients signed up to online services.

All B&NES surgeries offer appointment booking online, and since November 2015, the majority also offer a 24-hour automated phone booking system. Many practices also offer other services online including ordering repeat prescriptions and viewing GP patient records.

We received funding in support of practice resilience and development and were successful in securing additional investment of £3.8 million from the Estates and Technology Transformation Fund.

This funding will support three exciting projects:

New build – Hope House Community Hub
A new primary healthcare facility and community hub for Radstock and the surrounding area.

Improvement – Expansion at Oldfield site
Development of a new Multispecialty Community Provider (MCP) facility in central Bath.

Technology – Patient Activation and Access
Implementation of online consultations and new websites across all practices plus extended funding for the Patient Partner telephone booking system.

We also obtained consent from our member practices to take on the role of delegated commissioning of primary care from NHS England from 1 April 2017. This will allow us to develop a more joined-up vision for primary care, aligned to wider CCG and STP plans for improving health services.

3. Learning disability

During 2016/7 we continued working with local registered housing providers to create new homes for people in B&NES. We worked with Curo – a not-for-profit housing and support organisation – to help move people into a cluster of six flats on a new-build site in Keynsham. A further four people will shortly be moving into new flats in Midsomer Norton, developed in partnership with Aster Housing and Swallow.

The Banes Networks Community Interest Company (CIC) is a local group of adults with learning disabilities, funded by the CCG and Council to complete quality checks as 'Experts by Experience'. In 2016, the group carried out a quality check of the RUH, a local GP surgery and our programme of support services for those with learning difficulties.

These quality checks were the first of their kind to be carried out on primary and secondary care services by the Banes Networks CIC and the team presented their findings to the RUH Quality Board and the CCG Quality Committee, to ensure that appropriate actions were implemented.

Overall, the quality checks were well received in both settings. They focused on evaluating patient experience for people with a learning disability in five areas, including accessibility in the environment and the availability of accessible information.

The quality checking process highlighted areas of good practice in the acute as well as primary care setting. For example, specific services within the RUH were identified for having supportive and helpful staff. Furthermore, the staff team at the GP surgery were described as welcoming, respectful and eager to think of ideas that could improve the experiences of patients with learning disabilities.

Banes Networks CIC has also held 12 training courses for local support workers, led by people with learning disabilities. The courses look at choice and control, safeguarding, and The Mental Capacity Act from the perspective of someone with a learning disability. Over 200 support staff attended these sessions and we have had very positive feedback.

We are developing a local service to support people with complex and challenging behaviours. This will enable people previously supported in out-of-county placements to move back to the local area.

An innovative project by our community services provider Sirona's Learning Disabilities and Healthy Lifestyle Service won the top prize in the Learning Disabilities Nursing category of the Nursing Times Awards. The Journey to Wellbeing Project impressed the judges for offering joined-up support across services and the involvement of service users in its production.

We were also successful in a bid to the Department of Health Housing and Technology Capital Fund and will receive £456,800 to support two projects in 2017/18. One of these projects will provide technological support for people with

learning disabilities who live in their own home, and will see five people buy their own home under a Government-approved shared ownership model known as HOLD (home ownership for people with long term disabilities). We will deliver these projects alongside a range of partners including West of England Care and Repair, Advance Housing and Curo.

4. Optimising our use of medicines

GPs wrote four million prescriptions, at a cost of £25 million, for people in B&NES during 2016/17. 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.

The team has continued to focus on the ten priorities outlined in the CCG Medicines Strategy (which you can read in the Documents section of the CCG website under 'Strategies') which was launched in 2016.

Some examples of progress made on these priorities include:

- Launch of Type 2 diabetes prescribing guidance, which can be read on the Bath Clinical Area Partnership Joint Formulary website http://www.bcapformulary.nhs.uk/ and includes such advice to prescribers as how to reduce the risk of cardiovascular disease.
- Ongoing collaborative work around the appropriate use of antibiotics. This is resulting in reduced prescribing of antibiotics – in particular broad spectrum antibiotics.
- A very successful antibiotic awareness campaign with Year 3 primary school children; we also had the highest per-population sign-up rate to Public Health's Antibiotic Guardian campaign in 2016. The school campaign has been shortlisted in the community engagement section of the National Antibiotic Guardian Awards.
- An education session delivered to GPs and other health care providers on the area of complex pain and opioid therapy.
- The launch of the 'Think Kidneys' campaign in B&NES, including well-attended education sessions for GPs.
- We continued our work on the use of Anticoagulation for stroke prevention.

5. Mental health services

As part of the review, re-design and re-procurement of community services in B&NES, mental health and public health commissioners worked together to write a specification for a new 'wellness' service. The service aims to integrate mental and physical health and will involve social prescribing, healthy lifestyle advisers and motivators and the B&NES Wellbeing College.

It is envisaged that the wellness service will work seamlessly alongside the current mental health community-based care pathway, and a review of that pathway has begun. This review will look at the transition between children's and adult services,

drug and alcohol services and housing services, as well as ensuring a holistic approach is taken in supporting people with mental health issues. The review will be completed by September 2017, and changes to the pathway implemented in March 2018.

A new app has been developed called ROVa, which will launch in summer 2017 and allow people to generate and manage their own social prescriptions – with support if needed. The app will also include a volunteering module, so that volunteering opportunities can be included as part of a person's social prescription.

Social prescriptions offer an alternative to medical prescriptions. They include a range of social opportunities that enable people to better manage their condition, as well as improving physical and mental wellbeing. The goal is to reduce the frequency of GP visits by patients whose attendance rate is high by providing support in their community.

We have also developed a new mental health service user charter for B&NES, which is written into all mental health and wellness service specifications to ensure a consistent, high quality experience for service users. It acknowledges their rights and wishes and work is underway to develop a toolkit and training to help providers implement the charter.

Early in 2017 we were successful in securing an additional £450K in funding for Improving Access to Psychological Services (IAPT) through the transformation fund that was established by NHS England to support delivery of the Five Year Forward View.

6. Dementia

Whilst our overall dementia diagnosis rate is below target (see page 24), across B&NES the number of people aged over 80 years diagnosed with dementia, is in line with expected numbers for our region. All patients suspected of having dementia are referred for a comprehensive assessment and if appropriate, will have access to a range of support services.

In February 2017, the CCG signed up to the BaNES Dementia Action Alliance (DAA). The DAA aims to improve the lives of people with dementia in our local area by creating a dementia-friendly community. At the CCG we have pledged to: improve knowledge of dementia amongst our own staff, including board members; encourage our GP practices to become dementia-friendly, and encourage our providers to consider dementia-friendly design ideas when carrying out any refurbishments of their buildings.

A large group of CCG staff recently attended a 'Lunch and Learn' session given by representatives from the Alzheimer's Society about becoming a 'dementia friend'.

7. Improving diabetes care

We have been working hard to improve treatment for patients with diabetes over the past two years, aiming to deliver as much care as possible out of hospital, but with robust support from specialists.

In 2016/17, more GP practices across B&NES benefited from multidisciplinary diabetes team meetings in which a secondary care diabetes consultant and a diabetes nurse facilitator visit the practice to deliver education and advise on how best to treat complex patients.

We also began a Local Enhanced Service to enable GPs to initiate visits to housebound patients to assess their risk of developing diabetes, and/or check up on how they are managing the condition.

The CCG was successful in bidding for national diabetes transformation money in collaboration with the RUH and are excited to be able to further improve diabetes services locally during 2017/18. We will receive over £200K including funding for health education and to employ diabetes inpatient specialist nurses (DSNs) to reduce length of hospital stay for patients with diabetes.

8. Urgent care

During 2016/17, we piloted a number of initiatives that aimed to get people in to hospital for treatment sooner, and therefore back home to recuperate sooner.

Earlier Home Visiting Service

Three schemes were designed to enable home visits to happen more quickly for those most at risk of hospital admission:

- A specialist paramedic-led service in Bath, supported by Banes Enhanced Medical Services (BEMS+)
- GP-led service in Norton Radstock supported by BEMS+
- GP-led service in Keynsham run by group of practices.

Feedback from all three schemes shows they have helped reduce GP workload and helped avoid hospital admission.

We intend to introduce the Early Home Visiting service in all our GP practices over the coming year.

Urgent transport service

Sometimes patients who need treatment do not arrive at hospital early enough for their treatment to take place on the same day, which results in unnecessary

admissions. This year, we piloted the Health Care Professional Transport Service to move such patients directly to the RUH within an hour of referral, to maximise their opportunity for on-the-day treatment and discharge. The service also provides return transport for patients.

The pilot commenced in August 2016, and is operated by the F.A.S.T Ambulance Service on our behalf. Feedback has already shown a reduction in transfer delays for these complex patients and increased confidence that patients are not being left at risk because of demands on the 999 service.

Furthermore, the service facilitates on-the-day transfers from the Emergency Department and ambulatory care service at the RUH, reducing the need to admit patients who can return home.

Urgent Connect

The Urgent Connect system allows primary care and secondary (urgent and emergency) care clinicians to consult with each other, saving on unnecessary admissions and attendances. The pilot commenced in August 2016 and builds on our exciting Consultant Connect service in B&NES, which allows GPs who are with a patient to call a consultant directly and receive advice about treatment and whether a patient requires hospital admission. Urgent Connect can also take calls made via a smartphone app, making access very straightforward for GPs. We plan to expand this pilot further over the coming year.

Overall, the percentage annual growth in the number of patients admitted to hospital has fallen and the number of patients over 65 years who present early in their illness has increased and both of these positive results can be linked to our urgent care initiatives.

Home First

There has been a system-wide agreement to move towards a ‘Home First’ discharge model in B&NES, to improve discharge experiences and outcomes for patients.

The principle of Home First is that, where safe, all patients are discharged home. Health and social care assessments are traditionally completed in acute hospitals, but the goal with Home First is to carry them out in the most appropriate environment for the patient.

If a patient is unable to return home, then temporary options need to exist to allow assessments to be undertaken in an environment that meets their current need.

This model provides a range of support according to patients’ needs and allows them to be as independent as possible in their preferred environment for as long as possible.

In line with national guidance, the B&NES System Resilience Group was replaced in September 2016 with an A&E Delivery Board whose core responsibility is to ensure we achieve the target for all patients to be admitted, transferred or discharged from A&E within four hours.

9. Children's services

We continue to work closely with the Council to support children and young people in B&NES and have made a number of improvements to our services over the past year.

Integrated Personal Commissioning (IPC) budgets give children, their carers and families the opportunity to take an active role in their own health and wellbeing and greater control and choice about the care they need. There are now 10 IPC budgets being used in B&NES to fund short breaks, which is more than double the number seen in the previously commissioned service. There is now an established Designated Medical Officer (DMO), Designated Clinical Officer (DCO) and Commissioner, who keep clinical expertise at the heart of IPC decision-making.

A paediatric consultant triage service has been established, funded jointly with Wiltshire CCG. We have also supported the RUH with launching a new mobile app which provides expert advice to parents, carers and health professionals on common childhood illnesses. A new online mental health support tool called Kooth was launched in B&NES aimed at secondary school-aged children.

Oxford Health NHS Foundation Trust has been selected as preferred provider to take over Child and Adolescent Mental Health Services in April 2018. This re-procurement process has involved input from a panel of young people, and further consultation is planned to ensure the new services are designed with the input of those young people, their families and wider stakeholders.

Performance Analysis

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 NHS England to ensure our performance is in line with or exceeds these targets. Additionally the CCG Improvement and Assessment Framework (IAF) measures our performance in the four domains; Better Health, Better Care, Sustainability and Leadership. We meet monthly with NHS England to discuss our progress.

As demonstrated in our self-assessment in Figure 1 on the next page, the CCG is performing well in the area of Better Health. In Better Care there are a number of indicators where the CCG is performing well, for example, Mental Health is rated as a top performing service nationally. However, improvement is required for performance against the A&E four-hour standard, referral-to-treatment within 18 weeks and the dementia diagnosis rate. Our cancer waiting times targets have also faced pressures in Quarter 4. We have given ourselves a rating of 'Requires Improvement' overall for Better Care.

The Sustainability domain is also rated as Requires Improvement. Though performing well in most areas, there have been financial challenges, and although we have met our statutory duties, we did not meet the NHS England requirement to deliver a planned surplus.

Unfortunately with two of the IAF domains rated as Requires Improvement, NHS England may review our rating for the Leadership domain.

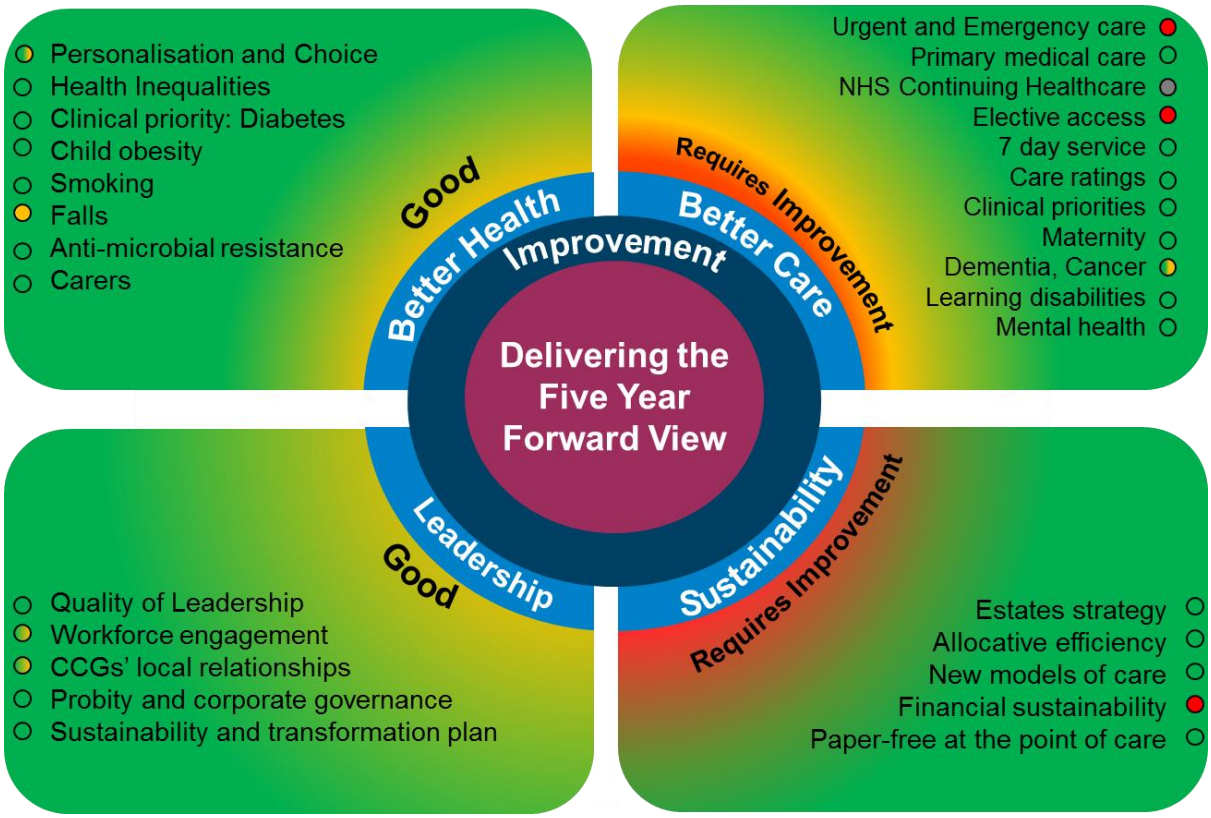


Figure 1 self-assessed Improvement and Assessment Framework (IAF) for 2016/17

The tables overleaf provide further detail about performance against the specific indicators within the areas Better Care and Better Health.

Better Care

IAF Standard	Target (Nat. avg)	2016/17 (or date available)	Commentary
Provision of high quality care – Hospitals	- (-)	60 (16/17 Q3)	The local hospitals commissioned by the CCG perform well in this CQC scored measure and are among the higher performers in its group of similar CCGs.
Cancers diagnosed at early stage (stage 1 or 2)	- (50.7%)	53.6% (2014)	The latest performance published is for 2014. A this point the CCG was better than the national average and moving towards the top quartile. The CCG's Operational Plan identifies a range of measures to support improved early diagnosis, such as ensuring that the latest advice and guidance is easily accessible to GPs. There are no national targets but these planned measures aim to help the CCG achieve the 62 per cent target by 2020 proposed by the South West Cancer Alliance.
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	85.0% (82.3%)	89.8%	B&NES performed above both the target and the national average in 2016/17. The local target of 88.4 per cent has been met in seven months of the year, driven by strong performance at the RUH. While Q4 performance fell marginally below the target at 84.4 per cent, the target was missed by one breach as complexity of pathways and patient choice both affected performance. The CCG has modelled demand to understand the likely impact over the coming two-year planning period and this will be kept under review to ensure that sufficient activity has been commissioned for 2018/19.
One-year survival from all cancers	- (70.2%)	71.6% (2013)	Performance for 2013, the latest available, is in the top quartile nationally and second in its group of 10 similar CCGs. The CCG expects to achieve the 2020 goal of 75 per cent one-year survival for all cancers.
Cancer patient experience	- (-)	87% (2015)	Cancer care commissioned by the CCG is performing well and is scored similarly to neighbouring CCGs.
Improving Access to Psychological Therapies recovery rate	50.0% (48.4%)	64.7% (Mar 2017)	Performance in this area continues to exceed targets set with our provider. Nationally the service is regarded as one of the highest performing. Commissioners meet with the Provider on a monthly basis to review performance and quality of the service.
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral	50.0% (77.2%)	100.0% (Mar 2017)	This is a new national target for 2016/17. All patients with first-episode psychosis started treatment with a NICE recommended package of care within two weeks of referral in January. Commissioners meet with the providers on a monthly basis to review performance and quality issues.
Children and young people's mental health services transformation (a measure of delivery of mandated transformation in 2016/17)	- (-)	70% (Q2 16/17)	The CCG's delivery of transformation is similar to its 10 closest CCGs. It looks at deliveries for Children and Young People, Crisis care and Out of area care. Though year end results are expected to be over 80%, some transformation has extended timelines where BANES are collaborating on some wider regional work.
Crisis care and liaison mental health services transformation (a measure of delivery of mandated transformation in 2016/17)	- (-)	92.5% (Q2 16/17)	Delivery of transformation is in the top quartile nationally and the CCG is first in its group of 10 closest CCGs. Year end results are expected to show full delivery of change but outcome measurement is still in development.
Out of area placements for acute mental health inpatient care - transformation (a measure of delivery of mandated transformation in 2016/17)	- (-)	25.0% (Q2 16/17)	The management of out of area placements has been developed in year, through oversight and scrutiny of decisions on, and numbers of, out of area specialist care going through a panel. Monitoring out of area placements now includes a Risk Sharing Panel with the Council and AWP. This should improve the year end score to amber. The results are impacted by the lack of a Psychiatric Intensive Care Unit in the area. The re-provision of inpatient services is being pursued by the commissioners and the provider and is proving difficult.

Better Care continued

IAF Standard	Target (Nat. avg)	2016/17	Commentary
Reliance on specialist inpatient care for people with a learning disability and/or autism	47 (-)	41 (Q2 16/17)	This indicator is measured for the Bristol, B&NES and South Glos Transforming Care Partnership and is performing well against target. Locally, only one BANES resident is in specialist inpatient care and their case is being closely managed.
Proportion of people with a learning disability on the GP register receiving an annual health check (aged 14 plus)	- (37.1%)	35.4% (2015/16)	Performance for 2015/16 is just below the national average and reduced when this measure moved from 18 yrs+ to 14 yrs +. However, local data suggests that more health checks were undertaken than are included in the national data, with performance at 84 per cent for the 18+ group. Each of the local GP practices has a named community LD nurse linked to the practice who works closely with LD liaison services in the RUH. The LD nurses work with public health colleagues to support access to the national screening programme where appropriate. Support for people aged 14 to 18 continues to be developed.
Neonatal mortality and stillbirths	4.7 (7.1)	4.7 (2014/15)	There are low neonatal mortality and still births in the CCG population for 2014/15, this performance was in the top quartile nationally. While more recent data is not available against this specific indicator, stillbirths and neonatal deaths at the RUH have seen spikes over the period up until the end of September '16, so performance may see a decline at the next data publication. The RUH is actively implementing the Saving Babies Bundle for which there is a CQUIN in place this year.
Women's experience of maternity services	- (-)	87.1 (2015)	Maternity care commissioned by the CCG is the top performer nationally for this measure using the CQC National Maternity Services Survey.
Choices in maternity services	72.4 (-)	72.4 (2015)	Choice in maternity services is in the top quartile nationally and second in its group of 10 similar CCGs.
Estimated diagnosis rate for people with dementia (diagnoses as % of prevalence)	67% (68.0%)	62.7% (Mar 2017)	This target continues to prove challenging following the increase in the nationally set estimated prevalence. Practice pharmacists have re-run the search for patients on dementia drugs, finding 59 patients that were not previously coded although this may only serve to prevent a further decline due to increased deaths over the winter period. The CCG is also investigating how to use primary care coding data to find more dementia patients.
Dementia care planning and post-diagnostic support (GP annual reviews)	- (-)	80.4% (2015/16)	BaNES GPs are performing well providing annual reviews for people with Dementia. BANES also has a wealth of post diagnostic support options available including: post diagnostic counselling, advance care planning sessions, post diagnostic support groups, memory cafes and respite/sitting services and singing for the brain groups to support the good performance.
Achievement of milestones in the delivery of an integrated urgent care service	- (-)	7 (16/17 Q2)	The CCG has the joint highest results for this indicator in its group of CCGs that share similar demographics and is in the top quartile nationally.
Emergency admissions for urgent care sensitive conditions (per 100,00 registered patients)	- (2359.2)	1837 (15/16 Q4)	Performance is in the top quartile nationally and second in its group of 10 closest CCGs showing good results in reducing avoidable admissions.
Percentage of patients admitted, transferred or discharged from A&E within 4 hours. (Provider data attributed to CCGs)	95% (88.4%)	80.6% (Mar 2017)	The CCG activity is below plan for A&E attendances but converting to just above plan for non-elective attendances, reflecting complex needs and timing of attendances. The 4-hour standard is measured and managed locally at provider level, BANES CCG focusses on the system around the RUH with a monthly A&E Delivery Board (A&EDB) actively overseeing the delivery of the 4-hour System Improvement Plan.. Performance at the RUH has been below the planned trajectory. Factors affecting performance include demand (other CCGs), Delayed Transfers of Care, the acuity of patients admitted and the closure of beds due to flu and Norovirus over the winter.

Better Care continued

IAF Standard	Target (Nat. avg)	2016/17 (or date available)	Commentary
Ambulance waits	75% (-)	74% (Feb 17)	During October SWASFT was mandated to introduce Ambulance Response Programme (ARP) version 2.2 and this has introduced a new change to the response and transport targets timeframes. Although the data is affected by the number of reporting changes in year. BaNES performance has seen an improvement compared to 2015/16
Delayed transfers of care attributable to the NHS per 100,000 population	- (15.0)	8.1 (Nov 16)	Performance is below (better than) the national average, with the CCG in the top quartile nationally according to the latest nationally available data. However, pressures on the urgent care system have caused performance to decline towards the end of the financial year and the RUH identified and fixed a reporting issue that will impact this result.
Population use of hospital beds following emergency admission (per 1000 registered population)	- (1.0)	0.9 (16/17 Q1)	BANES (CCGs) population's bed usage performance is below (better than) the national average and is just outside the top quartile nationally.
Management of long term conditions - unplanned hospitalisation for chronic ambulatory care sensitive conditions (per 100,000 registered population)	- (795)	629 (15/16 Q4)	BANES CCG has commissioned management of long term conditions working with primary care and has low avoidable admissions below the national average and in the top quartile nationally.
Patient experience of GP services	- (85.2%)	93.9% (2015)	BANES patients are reporting their experience of GP services significantly above the national average and among the top performing CCGs for this measure.
Primary care access (% of practices offering extended access weekend and evening - all 7 days)	- (-)	0% (16/17 Q3)	While recorded performance against this indicator appears poor (zero GP practices offering 7 day extended services), all CCG GP practices are providing extended access in accordance with previous guidance to provide access in the most cost effective way to meet the needs of the population. No practices currently offer Sunday appointments as they were trialled and take up was low, so sessions have been moved elsewhere to extended hours where demand is higher. The funding for every day access starts in 2018/19 and the CCG is investigating how it may provide efficient services at evenings and weekends to meet this target, including hubs at GP cluster level. The CCG is planning to meet the national target of 100% practices be the end of 2018/19.
Primary care workforce (Gps and Nurses FTE per 1000 patients in CCG)	- (1.0)	1.1 (Mar 2016)	The CCG is above the national average.
Patients waiting 18 weeks or less from referral to hospital treatment	92% (90.6%)	91.0% (Mar 2017)	The performance for CCG patients has remained below the national target throughout 2016/17. However, the 18-week waiting list has reduced significantly since its peak in May 16. Acute Providers continue to follow specialty improvement plans where required but non-elective emergency pressures have impacted on surgical capacity over the winter. The independent sector has performed well throughout the year.
People eligible for standard NHS Continuing Healthcare	- (46.2)	31.7 (16/17 Q2)	This measure has been subject to discussion between the CCG and NHSE to determine what constitutes good performance. NHSE would like the CCG to evidence that eligibility is being identified where ever needed while the CCG has reviewed all current Continuing Healthcare patients to ensure they are receiving the most appropriate care under NHS guidance which has reduced the number eligible.

Better Health

IAF Standard	Target (Nat avg)	2016/17 (or date available)	Commentary
Maternal smoking at delivery	- (10.4%)	8.3% (16/17 Q2)	BaNES CCG population has less women smoking at the time of delivery than the national average.
Percentage of children aged 10-11 classified as overweight or obese	- (33.2%)	27.3% (2014/15)	The low results for this measure in the national child measurement programme for 2014/15 mean BANES was in the top quartile nationally for this measure.
Diabetes patients that have achieved all the NICE recommended treatment targets:	- (39.8%)	40.1% (2014/15)	Diabetes care for the CCG population is performing well, just above the national average.
People with diabetes diagnosed less than a year who attend a structured education course	- (5.7%)	6.8% (2014/15)	The diabetes education programme commissioned by the CCG benchmarks well nationally, with performance moving towards the top quartile. We work with practices to ensure that our high participation rate in the National Diabetes Audit is maintained. A successful bid was submitted for the Diabetes Transformation Fund, with one of its aims being to improve the uptake of structured education.
Injuries from falls in people aged 65 and over (per 100,000 population)	- (1,985)	2,066 (Jun 2016)	Emergency admissions due to falls in BANES are higher than the national average and we have reduced the number of injuries from falls compared with 2015/16. The CCG plans to reduce non-elective admissions related to falls via prevention in the community. This will include rapid response services connected through a new Care Co-ordination Centre delivered by Virgin Care.
Utilisation of the NHS e-referral service to enable choice at first routine elective referral	80.0% by Sept 2017 (51.1%)	47.8% (Sep 2016)	The proportion of referrals for the CCG's population going through the e-referral service is on an improving trend but below the national average and with a significant uplift required to meet the national trajectory. The CCG's working group looks at both data issues and potential expansion to new services and is aligned with the STP demand management group which also undertakes work impacting this target.
Personal health budgets (number per 100,000 population)	- (18.7)	16.6 (16/17 Q2)	The CCG continues to develop access to personal health budgets as appropriate. (The national average is skewed by the best performing CCGs.)
Percentage of deaths which take place in hospital	- (47.1%)	40.0% (16/17 Q1)	A high proportion of the CCG population are supported to die in their normal place of residence. So the numbers of people dying in hospital are lower than the national average and in the top quartile nationally.
People with a long-term condition feeling supported to manage their condition(s)	- (64.3%)	73.0% (2016)	Patients in B&NES are supported to manage their long term condition through a number of services including: community heart failure service, dementia post diagnostic support services, pain coping skills and a cancer survivorship programme. We also have high performing mental health services compared with other areas of the country.
Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions	- (929)	857 (15/16 Q4)	This measure identifies the gap in these admissions between least and most deprived areas (LSOAs) within BANES . The gap is lower for BANES than the national average.

Better Health continued

IAF Standard	Target (Nat avg)	2016/17 (or date available)	Commentary
Inequality in avoidable emergency admissions	- (2,168)	1837 (15/16 Q4)	This measure identifies the gap in these admissions between least and most deprived areas (LSOAs) within BANES . The CCG is population has a lower gap than the national average.
Appropriate prescribing of antibiotics in primary care	- (1.069)	0.878 (Jan 17)	Prescribing within the CCG area is in the top quartile nationally.
Appropriate prescribing of broad spectrum antibiotics in primary care	13.2% (9.1%)	12.4% (Jan 17)	The CCG prescribing of broad spectrum antibiotics has and continues to reduce meeting its local target in the Quality Premium..
Quality of life of carers	- (80.%)	82.% (2016)	High levels of people in BANES who are carers are reporting a good health status, so the CCG's results are in the top quartile nationally.

Our performance under the areas of Leadership and Sustainability can be gleaned from the narrative that follows in subsequent pages rather than via formal reporting data. For example, the performance and effectiveness of our Board is detailed on page 62. Likewise, we explain how we collaborate with key partners and providers earlier in the report on pages 10 and 11, as well as how we engage with our staff.

Seeking to improve health outcomes and the quality of health services for the whole of our region is at the heart of all of our engagements. You can read how this focus plays a role in our emerging STP on page 11, including the five key priorities to create locality-based integrated teams that support primary care.

Compliments, concerns and complaints

The CCG views compliments, concerns and complaints as a rich source of valuable information and acts 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 ensure that any concern or complaint raised by any individual is dealt with compassionately, effectively and in a timely manner.

In 2016/17, the CCG received a total of 14 complaints and 8 compliments. One complaint, relating to a continuing healthcare (CHC) assessment was referred to the Parliamentary Health Service Ombudsman (PHSO). This complaint was originally raised in 2014 and is therefore not included in the above number. The PHSO partially upheld this complaint.

Most individuals provide feedback directly to the provider of care, whether they are satisfied or unhappy, which explains the low number received by the CCG. There have been 140 patient advice and liaison service (PALS) contacts in 2016/17.

The following are examples of remedial actions implemented to prevent recurrence:

- The implementation of individual journey monitoring for non-urgent patient transport services
- Additional support to enable more timely continuing healthcare assessments

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

Any individual or organisation wishing to submit feedback to the CCG, can contact PALS on freephone 0300 013 4762 or email BSCCG.Feedback@nhs.net. These details can also be found on the ‘Contact us’ page of our website.

Progress against national priorities

NHS England provides the CCG with support, tools and packs of data to help us know ‘where to look’ as a first stage to identify real opportunities to improve outcomes and increase value for local populations. We attend quarterly assurance meetings with NHS England, which represent an opportunity to perform a ‘deep dive’ into one particular service to check our performance. This year, these meetings have covered mental health, end of life, cancer and maternity care.

Dementia

In 2016/17 our dementia diagnosis rate was below target. The target requires us to formally diagnose two thirds (67 per cent) of all people estimated to have dementia in B&NES. Whilst it is disappointing not to achieve the target, our regional dementia lead confirmed that we have done all we can to raise our dementia diagnosis rate. Our inability to achieve the target is due to inaccuracy in the way the national target is set. It takes no account of local factors such as cardiovascular risk, deprivation or rurality.

Heart failure

Referrals for the community echo-cardiology clinics continued to increase during 2016/17. The CCG increased the funding for the service which allowed additional clinics to take place but whilst the waiting list was being reduced in the first half of the year, some patients breached the six-week diagnostic target.

Long-term conditions

The latest 'Commissioning for Value: Where to look' information pack was published in January 2017 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 and gastrointestinal problems. We need to improve early identification of patients with circulation and respiratory problems.

Mental Health

Our goal is to provide timely access to mental health services for all ages, with a clear patient pathway that also encompasses physical health outcomes. This form the commitment we have made in the Joint CCG and Council Mental Health and Social Care Commissioning Strategy. We also strive to alleviate the mental health burden on both emergency department and primary care settings via activity involving the Crisis Concordat group, psychiatric liaison service and police.

End of Life

Our local end of life strategy was agreed in 2016 and B&NES has the highest proportion of patients who die in their usual place of residence. The proportion of patients who die in hospital is falling, and is seven per cent lower than the national average. We are committed to early identification of people with life-limiting illnesses, including dedicated district nurse team involvement. We are also exploring using Personal Health Budgets for end-of-life care.

Cancer

Data from October 2016 shows we are performing well against national cancer targets but that we need to increase the numbers of cancers diagnosed at an early stage. Our plans to do this include working with our local public health teams and primary care colleagues on public and

patient messaging about healthy lifestyle choices, collaborative efforts to improve screening uptake rates and distribution of NICE two-week referral forms and patient leaflets explaining the importance of attending the two-week wait appointment.

We also recognise the need to improve patient experience (we received a rating of 8.7 out of 10 in the National Cancer Patient Experience Survey) right until end of life. The care pathway is a key focus for this as per our agreement in 2015/16 to implement recommendations of the National Cancer Survivorship Initiative for 'Stratified pathways of care for people living with and beyond cancer'.

Maternity care

Our plans to meet the recommendations of 'Better Births' – NHS England's five-year forward view for maternity care – are progressing with our STP neighbours Swindon and Wiltshire. Engagement with women in the region has been strong, with RUH-led engagement meetings and a survey about what women want from maternity services receiving 700 responses. Our work on Commissioning for Quality and Innovation indicators (CQUINs) is also having a positive impact, with a downward trend in stillbirths and a reduction in numbers of women smoking at booking versus at birth (see CQUINs section below).

Improve quality

The Quality Strategy and objectives for 2014/17 set out how the CCG will endeavour to ensure that high quality, safe care is always provided and that people experience better care from the services they receive. This strategy can be read on the CCG website under 'Documents' and 'Strategies'.

The CCG and all members of the Board are committed to achieving high quality clinical services. Clear medical and non-medical clinical leadership is provided and the Board is dedicated to ensuring that patients get the quality of care that is expected.

We take the need to provide equitable services that meet the needs of our population very seriously. The challenge is to ensure that B&NES residents have equitable access to health care that is effective, safe and of a proven quality, provided within available resources. We must also ensure that patients, service users and their families and carers are involved in decisions about their own health and have access to information to be able to make an informed choice. Quality in health and social care is integral to everything we do

We commission services from a number of providers and are associate commissioners, working in partnership with a lead CCG for others. The quality and safety of services is assured through quality schedules, CQUINs, monitoring the quality impact of cost improvement schemes and site visits to major providers. Reports are made publicly available at each Board meeting and at our Quality Committee, of which Healthwatch are members.

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.

Some areas of success during 2016/17 include:

- Improvement in the identification of patients with Acute Kidney Injury (AKI) and as a result, greater compliance with the recommended minimum requirements of care, the 'AKI bundle'.
- Increased awareness of severe sepsis and as a result, earlier detection, which allows more patients to be treated within an hour.
- 90 per cent achievement of the CQUIN target to refer pregnant women identified as smokers to a specialist smoking cessation service. This resulted in a reduction in the number of women who smoked at their first booking appointment versus at birth of 15 per cent to 8.5 per cent during quarter three.
- Our local CQUIN for staff health and wellbeing complemented the National CQUIN and we have seen the introduction of health and wellbeing initiatives in several of our providers. Across B&NES, a number of providers have signed up to the Workplace Wellbeing Charter and have been focusing on specific ations to raise the standards in their organisation to at least the 'Commitment' level in key areas including; leadership; absence management; health and safety, mental health and physical activity.
- Greater antimicrobial stewardship is evidenced in several of our providers with B&NES having the highest proportion of Antibiotic Guardians in the country.
- Increased and appropriate use of the National Early Warning Score tool to support early identification of the deteriorating patient in community and out-of-hours services.

Sustainability Report

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 2016/17 we have delivered the following:

- Raising awareness of our Sustainable Development Management Plan across the organisation through presentation to staff groups and formal reporting to the Joint Commissioning Committee and Board
- Improving consideration of sustainability factors in carrying out our ongoing business, for example in our Risk Register and in the development of business cases
- Adopting target reductions for expenditure on paper and for mileage
- Rolling out a paperless records and paperless meetings approach
- Completing initiatives to improve the working environment and staff wellbeing
- Ensuring compliance of our resilience plans with adaptation (to the effects of climate change) planning guidance
- Beginning to develop sustainability considerations within our Estates Strategy

During 2017/18 our focus will be on the following objectives:

- Delivering the second year of our action plan approved by the Board as part of the Sustainable Development Management Plan, and building on the successes of the first year, 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 2016/17 from all our activities including services commissioned by us is 50,145 tonnes of carbon dioxide equivalent emissions (tCO2 e) (2015/16 49,153 tCO2 e). Within this figure, 49,691 tCO2 e are related to healthcare services commissioned by the CCG (2015/16 48,691 tCO2 e) and a further 364 tCO2 e (2015/16 332 tCO2 e) was generated through procurement and contracted out business support services, for example the Commissioning Support Unit, auditors, and payroll.

The main reason for the increase in carbon emissions from 2015/16 to 2016/17 is our increased spend on commissioning healthcare. The increase in carbon emissions associated with contracted out business support services is notional, being driven by the higher cost of the CCG offices attributable to NHS Property Services restating rents to market value.

The figures reported in the 2015/16 annual report showed significantly higher volumes of carbon emissions due to an error in the modelling tool used to calculate the estimated carbon footprint. The CCG has liaised with the Sustainable Development Unit who has advised that the methodology used for 2016/17 is correct. The figures for 2015/16 have been restated to reflect the same methodology used in 2016/17.

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.

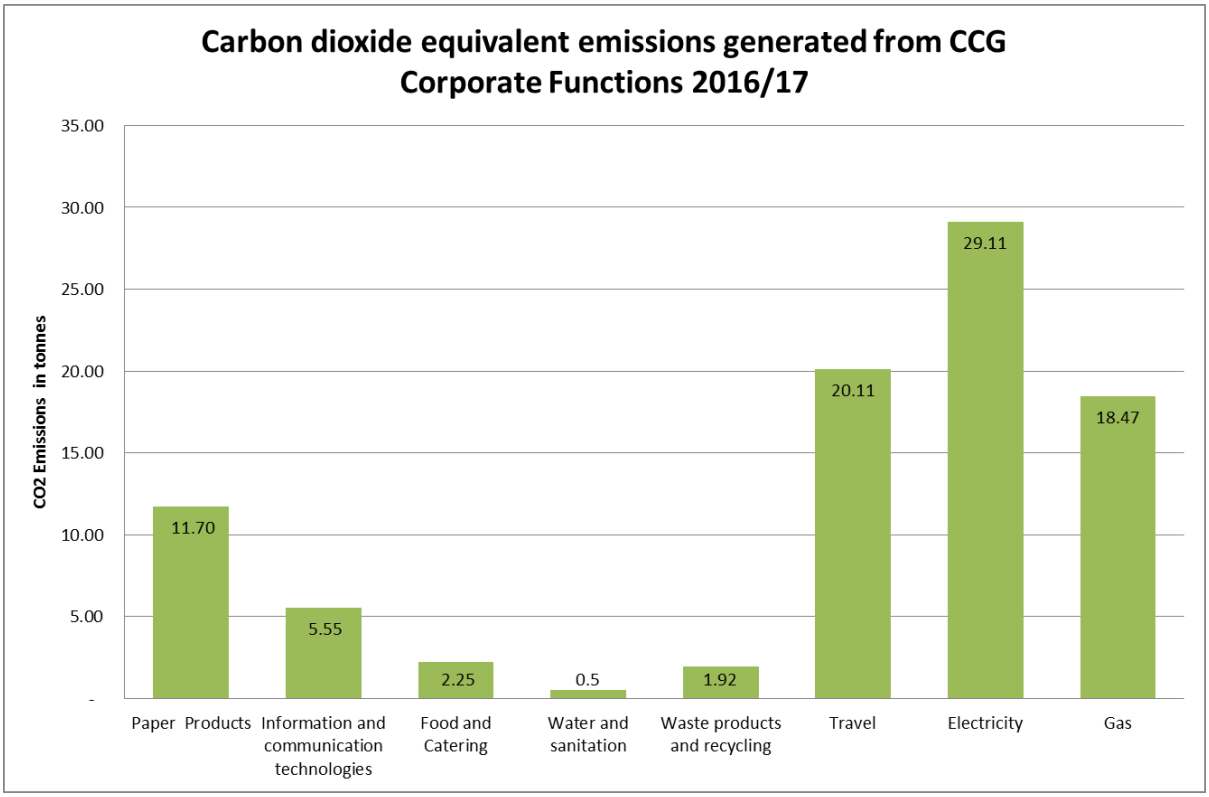
The CCG's carbon footprint is affected by the direct activities of our corporate and commissioning functions, and these areas are most easily influenced by CCG action.
In 2016/17, the CCG as a corporate body produced 89.61 tCO2 e compared to 129.39 tCO2 e in 2015/16 – a reduction of 30.74 per cent. As with the overall figures, 2015/16 figures have been restated to be comparable with the calculation methodology for 2016/17.

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

CO2Emissions (tonnes of CO2e)	2016/17	2015/16	Change in tCO2e	Percentage change
Paper products	11.70	12.45	-0.75	-6.02%
Other manufactured products	0	4.41	-4.41	-100.00%
Information and communication technologies	5.55	23.85	-18.30	-76.73%
Food and catering	2.25	1.28	0.97	75.78%
Construction	0	0.03	-0.03	-100.00%
Water and sanitation	0.5	0.28	0.22	78.57%
Waste products and recycling	1.92	1.62	0.30	0.00%
Travel	20.11	17.96	2.15	11.97%
Electricity	29.11	37.18	-8.07	-21.71%
Gas	18.47	30.33	-11.86	-39.10%
Total	**89.61**	**129.39**	**-39.78**	**-30.74%**

The reductions in emissions related to paper products, other manufactured products, and ICT are all as a result of decreased expenditure on these areas by the CCG between the two financial years. The increase in emissions related to travel is attributable to the additional travel required to engage in the Sustainability and Transformation Plan work across the B&NES, Swindon and Wiltshire area. The apparent increase in emissions relating to food and catering is due to our having incurred a higher than usual level of expenditure on items on behalf of other organisations, which has then been reimbursed.

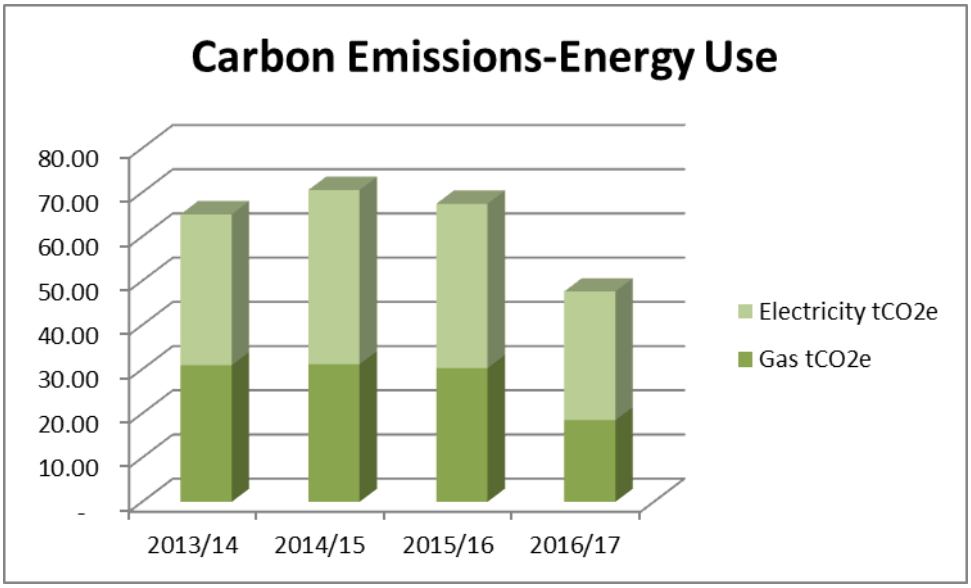
Further details regarding energy, water and waste are shown below.
The chart below illustrates the carbon impact of our actions as a corporate body during 2016/17.



Energy:

The table below and following chart show our expenditure on energy for 2016/17 as compared to the previous three 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 significant reduction in consumption of gas in year and there has been a small decrease in electricity consumption. Overall, the carbon emissions associated with the CCG's energy usage are lower in 2016/17 than in 2015/16 by approximately 29 per cent.

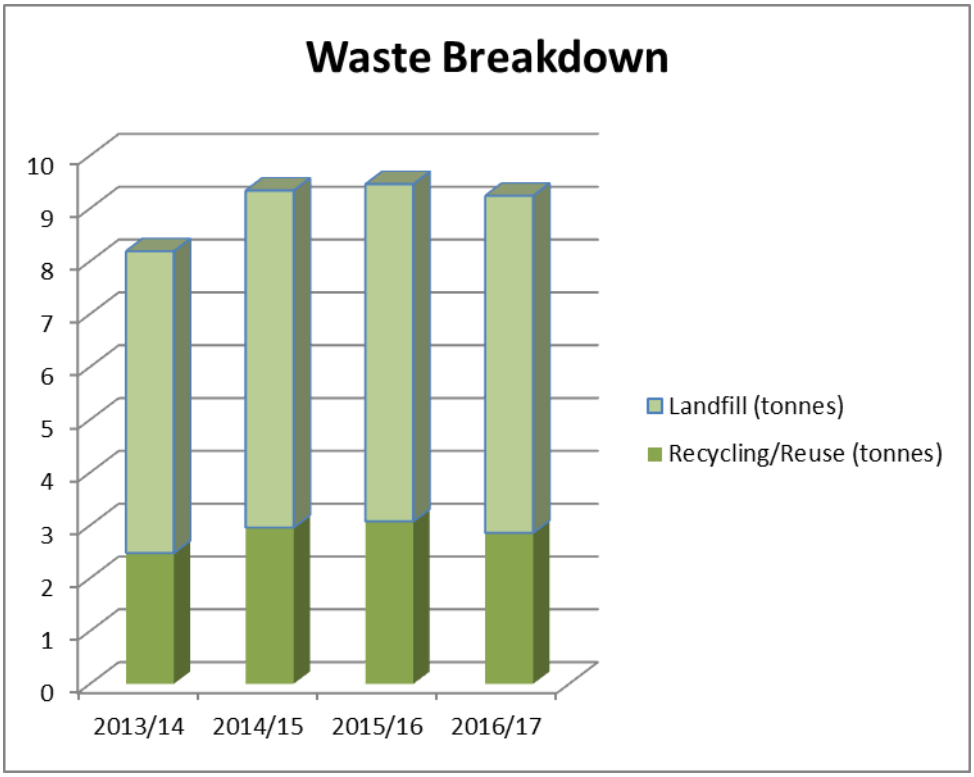
Resource		2013/14	2014/15	2015/16	2016/17
Gas	Use (kWh)	145,782	148,388	144,586	88,393
	tCO2e	30.93	31.13	30.26	18.47
Electricity	Use (kWh)	60,941	63,664	64,673	56,330
	tCO2e	34.12	39.43	37.18	29.11
Total Energy CO2e		65.05	70.56	67.44	47.58
Total Energy Spend		12,444	11,663	10,103	9,927



Waste:

The table below and following chart show the volume of waste arising from our activities and the resulting modelled carbon emissions impact. There has been a small decrease in total volume of waste. This is due to staff being more aware of our carbon footprint in line with our objectives for 2016/17. The reduction in tonnes of recycled or re-used waste is linked to the overall reduction in use of paper.

Waste		2013/14	2014/15	2015/16	2016/17
Recycling/Reuse	(tonnes)	2.48	2.96	3.08	2.86
	tCO2e	0.04	0.06	0.06	0.06
Landfill	(tonnes)	5.71	6.38	6.38	6.38
	tCO2e	1.40	1.56	1.56	1.86
Total Waste (tonnes)		8.19	9.34	9.46	9.24
% Recycled or Re-used		30.28%	31.69%	32.56%	30.95%
Total Waste tCO2e		1.44	1.62	1.62	1.92



Water:
The table below shows our expenditure on water and sewerage during 2016/17 as compared to the previous three years. As with energy, the data is based on apportioned usage across the St Martin's Hospital site. There has been an increase in water consumption between 2015/16 and 2016/17. We are working with NHS Property Services to identify what may have caused this.

Water		2013/14	2014/15	2015/16	2016/17
Mains	m3	447	695	306	548
	tCO2e	0.41	0.63	0.28	0.50
Water & Sewage Spend		£1,740	£2,737	£1,103	£1,979

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 continues to show a mixed picture.

The CCG is pleased to note that University Hospitals Bristol Foundation Trust and North Bristol NHS Foundation Trust have achieved an excellent score for their sustainability reporting and that Royal United Hospitals Bath NHS Foundation Trust has achieved a good score. In contrast other major providers have a poor score. These three acute providers and the South West Ambulance Service NHS Foundation Trust have in place Sustainable Development Management Plans and there are examples of good practice in individual organisations.

We continue to look at ways of increasing our engagement with providers on this important issue.

Patient and Public Involvement

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 have the opportunity to ask questions. We regularly invite patients to share their personal experiences of health and care at the beginning of these meetings.

Our Your Health, Your Voice group meets every two months, providing an opportunity for the public to feedback on 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. The topics covered in 2016/17 were:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult mental health services
- The future of community health and care services with Virgin Care
- Changes to prescribing policies for gluten-free and over the counter medicines
- B&NES, Swindon & Wiltshire STP
- Re-procurement of NHS111 and GP out-of-hours services

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 53.

From 24 November to 21 December 2016, we ran a programme of engagement as part of a review of our prescribing policy for gluten-free food and two types over-the-counter medicines (antihistamines and painkillers) when used to treat short-term minor ailments.

We received a lot of feedback from patients and professionals which had a significant influence on our final policy, ensuring that the most vulnerable people would still be protected.

We also took steps to increase our engagement with the 26 Patient Participation Groups (PPGs) that belong to our member practices. We held PPG Network Meetings in March and June, bringing together PPG representatives from across the B&NES to share ideas and find out more about the CCG's current projects.

Over 120 people attended our Annual General Meeting at Somerdale Pavilion, Keynsham on Thursday 29 September 2016. The guest speaker was Dr Nigel Watson, Chief Executive of the Wessex Local Medical Committee who shared his thoughts on the challenges facing general practice and what we can all do to ensure a healthy future for our local population.

Reducing health inequalities

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.

From the end of July 2016, it became law for all organisations providing NHS care to follow the Accessible Information Standard (AIS).

The AIS aims to ensure that people with disabilities can access information in a way that is understandable to them. This includes being offered alternative communications formats such as large print, braille and/or easy-read materials by organisations including NHS trusts, foundation trusts and GP practices, as well as organisations that pay for and make decisions about NHS and adult social care services such as CCGs and Local Authorities.

To support providers and to help ensure the success of this work, the CCG produced an information sheet and Accessible Formats Directory, which help identify when and how to access different types of communications support. We have also set up an Accessible Standard Implementation Group for providers.

To meet our goal of commissioning high-quality health services that recognise and value the diversity of our communities, we carry out equality analysis (equality impact assessment) as an integral part of commissioning projects.

Equality analysis uses a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on people of differing groups within our community. It aims to identify any discriminatory or negative consequences for a particular group or sector of the community, and to prompt us to consider what positive actions we need to take in order to meet the needs of people with protected characteristics. Equality analysis can be carried out in relation to service delivery as well as employment policies and strategies.

You can read more about our commitment to equality in our Public Sector Equality Duty Report 2016/17, published on our website under ‘Documents’ and ‘Policies and Governance’.

Health and wellbeing strategy

Local Health and Wellbeing Board

The CCG’s Clinical Chair, Dr Ian Orpen, co-chairs the local Health and Wellbeing Board alongside the B&NES Council Cabinet Member for Adult Social Care and Health, Cllr Vic Pritchard.

The CCG’s Chief Officer, Tracey Cox, is also represented on the Board and both CCG staff members are active in its ongoing development and agenda management.

The Health and Wellbeing Board has had a successful year and was included in a Local Government Association case study report about effective Health and Wellbeing Boards.

The Board has scrutinised its ability to deliver its strategy for the region, as well as its aspirations for integration and prevention. The Board's focus remains to adopt a place-based approach to putting people at the heart of reform.

The Health and Wellbeing Board wants to make the most of its collective knowledge, resources and service solutions by working better together. The Board recognises that it cannot stop at the boundaries of NHS services in this goal, and that it needs to reflect on the wider determinants of health such as housing, skills and employment. The Board has recently extended its membership to a wide range of provider and non NHS organisations to increase its effectiveness. The Board is also currently developing a refreshed terms of reference to acknowledge these developments and will present these in May 2017 for formal adoption.

The Board has also responded to key changes such as STP developments and the local re-design of community health and care services. The CCG plays a pivotal role in these meetings and brings regular reports on items such as Annual Commissioning Intentions.

The Health and Wellbeing Board's formal meetings are webcast live and are open to the public to attend.

Alongside this, the CCG also provides regular updates to the Health and Wellbeing Select Committee. The panel reviews and scrutinises the work of the CCG, Council and other organisations in relation to health and wellbeing.

Financial review

The CCG has achieved its statutory financial duties for the year.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1 per cent reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs'1 per cent non-recurrent monies to be spent. Therefore to comply with this requirement, BaNES CCG has released its 1 per cent reserve to the bottom line, resulting in an additional surplus for the year of £2.234m. This additional surplus will be carried forward for drawdown in future years.

We closed the year with a total funding allocation (Revenue Resource Limit) of £233.65m and operated within this for 2016/17, achieving a surplus of £2.32m. In addition to our statutory financial duty to operate within our Revenue Resource Limit, we were required in 2016/17 to deliver a planned surplus of one per cent or £2.3m and a further surplus of one per cent through releasing previously held funding, known as headroom, in accordance with national rules. We achieved the second of these requirements but not the first. Unfortunately, this gives the impression that the CCG's underlying financial position is healthier than it is. Put simply, if

we had been constrained to the funding allocated to us initially, we would have failed to meet our target surplus but would have just broken even. The late handover in month 12 to us of the 1% so called “headroom reserves” meant that we ended the year contra to earlier expectation, achieving our target surplus. The same assumption of late relief cannot be reckoned in 2017/18.

Savings schemes of £8.8m had been planned in 2016/17, of which £3.5 million were delivered in the year. The savings delivered included schemes to reduce avoidable visits to hospital and to reduce expenditure on drugs. The resources released were used to fund unavoidable costs pressures, nationally mandated investments, local investments in support of savings delivery and the costs of increasing demand.

The recurrent administration resource budget of £4.27m was underspent by £118k. This is mainly due to vacancies arising during the year.

More detail on our performance against statutory financial targets and duties now follows.

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 £2.32m (including one per cent headroom funding held).

	2016/17	2015/16
	£000	£000
Performance for the year ended 31 March 2017:		
Total Net Operating Cost for the Financial Year	**231,333**	224,796
Revenue Resource Limit	**233,649**	227,043
Underspend Against Revenue Resource Limit	**2,316**	2,247

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:

<u>Recurrent administration costs</u>

	2016/17	2015/16
	£000	£000

Performance for the year ended 31 March 2017:		
Administration Cost for the Financial Year	**4,150**	3,717
Administration allocation	**4,268**	4,178
Underspend Against Allocation	**118**	461

Non recurrent administration costs – Quality Premium allocation

	2016/17	**2015/16**
	£000	**£000**
Performance for the year ended 31 March 2017:		
Administration Cost for the Financial Year	**0**	**0**
Administration allocation	**0**	**529**
Underspend Against Allocation	**0**	**529**
Quality Premium expenditure within Programme Costs	**0**	**572**
Overspend on Quality Premium	**0**	**43**

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 of a valid invoice, 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.

	2016/17	**2016/17**	2015/16	2015/16
	Number	**£000**	Number	£000
Non-NHS Creditors				
Total bills paid in the year	**3,568**	**83,447**	3,928	86,334
Total bills paid within target	**3,425**	**81,953**	3,741	85,029
Percentage of bills paid within target	**95.99**	**98.21**	95.24	98.49
NHS Creditors				
Total bills paid in the year	**2,569**	**125,993**	2,486	116,828
Total bills paid within target	**2,466**	**124,815**	2,406	114,878
Percentage of bills paid within target	**95.99**	**99.07**	96.78	98.33

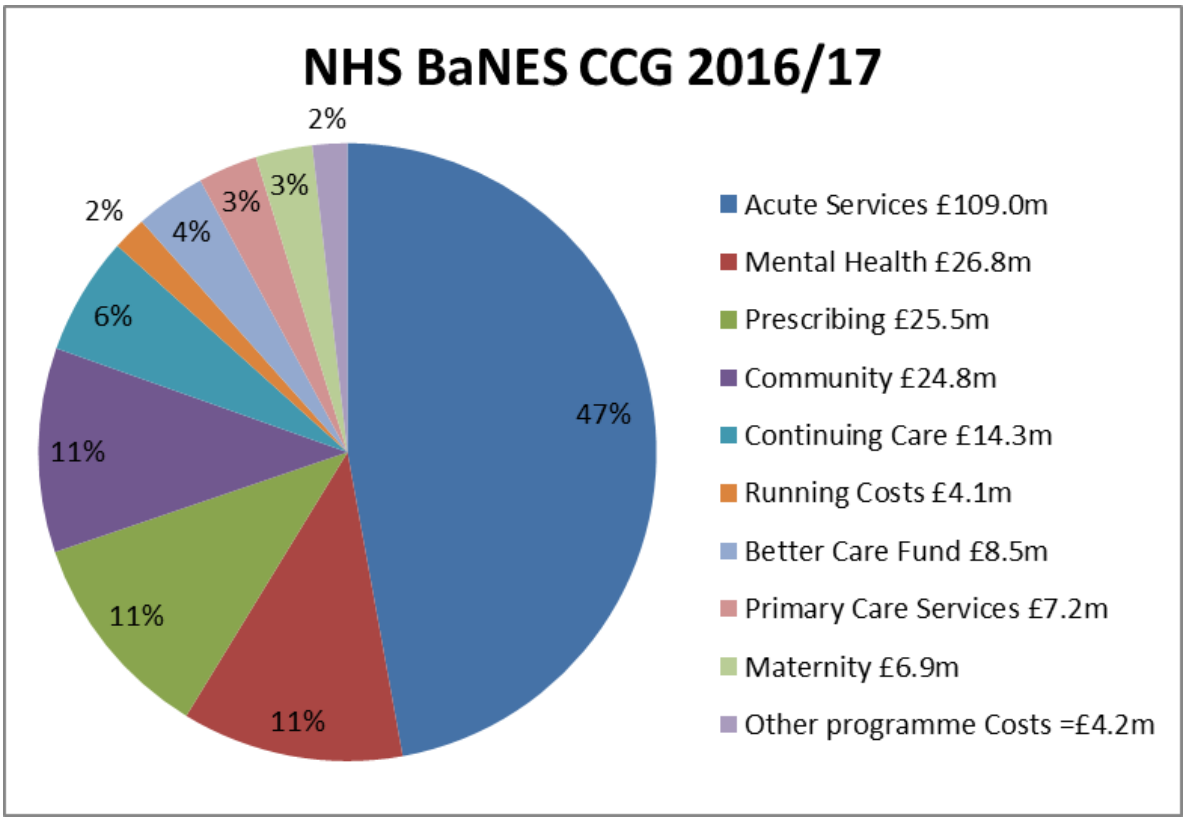
Cash position

Our financial statements show cash held of £169k as at 31 March 2017. 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 shows the types of services provided and illustrates how much we spent on each during 2016/17. Acute healthcare makes up the highest percentage of expenditure (47 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 future shift in the overall percentage of spends from acute healthcare to primary care and community care as pathways are redeveloped and services reviewed.



Future Financial Position

The CCG has submitted a financial plan for 2017/18 which plans to deliver a surplus of £72k. Planned net savings of £10.2m are required to offset increasing costs and activity pressures and to support priority investments. This is in line with our Operating Plan and our financial recovery 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.

Section 2
ACCOUNTABILITY REPORT

Signed:

Tracey Cox
Accountable Officer
25 May 2017

Corporate Governance Report

Directors Report

Clinical Commissioning Groups (CCGs) are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

Commissioning is about getting the best possible health outcomes for the local population, by assessing local needs, deciding priorities and strategies, and then buying services on behalf of the population from providers such as hospitals, clinics, community health bodies etc. It is an ongoing process, and CCGs must constantly respond and adapt to changing local circumstances.

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

Member practices

The following table details the 26 GP practices that comprise the membership of BaNES CCG*.*

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

Composition of the Board

The membership of our Board during 2016/17 is set out in the table below:

Board Members (voting)	
Dr Ian Orpen	Clinical Chair
Tracey Cox	Chief Officer
Dr Ruth Grabham	Medical Director
Dawn Clarke	Director of Nursing & Quality / Registered Nurse
Sarah James	Chief Financial Officer
Dr James Hampton	GP
Dr Elizabeth Hersch	GP
Dr Jonathan Osborn	GP

Dr Daisy Curling	Sessional GP (maternity leave from 22 September 2016)
Helen Harris	Practice Manager
John Holden	Lay Member (audit and governance) / Vice Chair
Suzannah Power	Lay Member (patient and public involvement)
Myles Taylor	Secondary Care Specialist Consultant
Members In Attendance (non-voting)	
Julie-Anne Wales	Head of Corporate Governance & Planning
Corinne Edwards	Head of Commissioning Development
Mike Bowden	Strategic Director People & Communities, B&NES Council
Bruce Laurence	Director Public Health, B&NES Council
Jane Shayler	Director, Integrated Health & Care Commissioning (BaNES CCG & B&NES Council)

Chair and Chief Officer (Accountable Officer)

The Clinical Chair of the CCG from 1 April 2016, 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 2016, throughout the year and up to the signing of the Annual Report and Accounts was Tracey Cox.

Board Member profiles

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. From 2008 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 until 2012. 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. I was reappointed as Chair in December 2016 for a further 4 years from April 2017.
Appointed to the Board April 2013	
Other roles:- Chair of CCG Board Member of Remuneration Committee Chair of Finance & Performance Committee Co-Chair of B&NES Health & Wellbeing Board Member of BSW STP Board Co-Chair BSW STP Clinical Board Member of BaNES A&E Delivery Board Member of West of England Academic Health Science Network Board RUH Council of Governors	

Stakeholder member B&NES Public Services Board member LGA Associate for Health and Wellbeing 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 across the whole health and care system including the role of the Council, primary care, mental health and hospital services I am Clinical Lead at the CCG for Prevention and Self Care

Chief Officer

Tracey Cox Chief Officer	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.
Appointed to the Board April 2013	
Other roles Interim Accountable Officer for Wiltshire CCG (from 26 September 2016 to 31 March 2017) Chair of Joint Commissioning Committee Chair of Transformation Group Chair of Executive Team Member of Finance & Performance Committee Chair of A&E Delivery Board Member of STP Leadership Group	

Executive Board Members

Dr Ruth Grabham Medical Director	I qualified from Charing Cross Hospital Medical School in London in 1987 and became a partner at Newbridge Surgery in Bath in 1993.
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 Finance & Performance Committee Member of Clinical Commissioning Reference Board	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 the Joint Committee for the Oversight of Joint Working Member of the Joint Primary Care Co-Commissioning Committee Member of Finance & Performance Committee Chair of the Information Governance Steering Group Member of the IM&T Steering Group HFMA South West Branch Treasurer HFMA Commissioning Finance Faculty Steering Group member	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 and the CCG in 2013. I remain committed to ensuring that we achieve value for money in the services we commission, by securing the best quality we can within the money we have available, as our financial challenge increases.

Dawn Clarke Director of Nursing & Quality and Registered Nurse Board Member	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 contracting and Performance Lead and, until 2013, as Assistant Director of Patient Safety and Clinical Quality at the NHS North West Strategic Health Authority. I am passionate about improving patient safety and quality of care and about working to reduce unwarranted clinical variation and improve outcomes I do not underestimate the challenge for the CCG in commissioning high quality safe and effective services for local residents during a time of challenging financial constraint. I am delighted to be working with the wider health and care system to deliver the STP in 2017 and beyond.
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 Finance & Performance Committee Member of Audit Committee Member of the Local Adult and Children's Safeguarding Boards, Health Protection Committee and other regional groups.	

GP Practice Representatives on the Board

Dr James Hampton GP Representative	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)
Appointed to the Board April 2013 – March 2017	
Other roles: GP Cluster Commissioning Lead Board Member (Bath Central), Member Joint Commissioning Committee Member of the Individual Patient Panel.	

Dr Elizabeth Hersch GP Representative Appointed to the Board April 2013 and re-appointed in April 2015 Other roles: Member of the Joint Commissioning Committee NHS 111 Clinical Governance Lead Member of the A&E Delivery Board	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. Project I have been involved are frailty, Acute Kidney Injury (AKI) and sepsis

Dr Daisy Curling GP Representative Appointed to the Board October 2014 Other roles: Member of Joint Commissioning Committee Member of Quality Committee	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. 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 Daisy was on maternity leave from September 2016.

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 in Bath and Wiltshire. 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 Chief Clinical Information Officer at the CCG, and am cluster lead for Chew – Keynsham. I am also responsible for Medicines Management
Appointed to the Board March 2016	
Other roles: Member of the Joint Commissioning Committee	

Practice Manager Representative on the Board

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

Lay Members on the Board

John Holden Lay Member (Audit and Governance) & Vice Chair	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 this period, I was also the Registrar of Political Parties.
Appointed to the Board April 2013 Re-appointed 1 September 2016	

Other roles: Chair of the Audit Committee Chair of the Remuneration Committee Member and Deputy Chair of Finance & Performance Committee Member of the Joint Primary Care Co-Commissioning Committee Member of the Quality Committee	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)	I have a range of experience across the private, public and charity sectors. My expertise lies in marketing, public relations and public involvement. For many years I represented the patient viewpoint on the British Heart Foundation Council, and was a member of several NICE Guideline Development Groups including Patient Experience in Adult NHS Services, Prevention of Cardiovascular Disease and Atrial Fibrillation Management. For four years I served as a member of the Research for Patient Benefit (NIHR) South West Region Funding Committee and reviewed applications regularly during that time. My interest in patient-centred research continues through involvement with a project at the University of Birmingham Centre for Cardiovascular Sciences. Alongside this I am chair of the National Health Literacy Collaborative, a group of organisations sponsored by NHS England, committed to thinking collectively about the role that health literacy plays in health and social care systems.
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 Member of Primary Care Operational Group Member of Primary Care Preparing for the Future Board	

Secondary Care Consultant Member on the Board

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 post was created 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 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 February 2016	
Other roles: Member of the Audit Committee Member of the Joint Primary Care Co-commissioning Committee	

As part of the CCG's process to strengthen arrangements around conflicts of interest, Katie Hall will become a Lay member on the Board from 1 April 2017.

Board Sub-Committees

Throughout 2016/17 the Board has had six sub-committees:-

- Audit Committee
- Quality Committee

- Remuneration Committee
- Finance & Performance Committee
- Joint Commissioning Committee (CCG and Council membership to support integrated working).
- Joint Primary Care Co-Commissioning Committee (CCG and NHS England membership to support joint commission primary medical services).

Full details of each Board sub-committee can be found on pages 66-72.

Register of Interests

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 Interests is maintained and published on the CCG's website under 'Documents' and 'Policies and Governance'. http://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/register-of-interests-2.

The management of conflicts within the CCG were reviewed extensively in 2016 following the NHS England publication "Managing Conflicts of Interest: Revised Statutory Guidance for CCGs". Key changes that resulted from a gap analysis and action plan were:-

- An additional lay member on the Board (effective 1 April 2017)
- Further strengthened the robust process for managing any breaches within conflict of interest policy and for anonymised details of the breach to be published on the CCG's website. The CCG can report that it did not have any breaches during 2016/17
- Introduced a conflicts of interest guardian. This role is held by the Chair of the Audit Committee
- Strengthened provisions around decision-making
- Strengthened provisions around the management of gifts and hospitality
- Introduced an annual audit of conflicts of interest management
- Developed an educational plan for all staff, which included annual training to commence in 2017/18.

An internal audit was conducted on the management of conflicts of interest in 2016/17 which provided an assurance rating of 'Significant Assurance with Minor Opportunities for Improvement' . All the recommendations were implemented.

Personal data related incidents

There were no personal data related incidents that were formally reported to the Information Commissioner's Office during 2016/17.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report

- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 is published on our website under 'Documents' and 'Policies and Governance'.
http://www.bathandnortheastsomersetccg.nhs.uk/documents/polcies-and-governance/modern-slavery-act-2015-statement

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Officer to be the Accountable Officer of Bath & North East Somerset CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include 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)
- For safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- The relevant responsibilities of accounting officers under Managing Public Money
- Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

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 Group Accounting Manual 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 Group Accounting Manual issued by the Department of Health have been

followed, and disclose and explain any material departures in the financial statements

- 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 under the National Health Service Act 2006 (as amended), Managing Public Money and 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 CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG'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:

Tracey Cox
Accountable Officer
25 May 2017

Governance Statement

Introduction and context

BaNES CCG is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

The clinical commissioning group's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2016, the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and 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. I also have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The main function of the Board is to ensure that the organisation has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

CCGs are legally obliged to set out their agreed governance arrangements in a publically available Constitution. The Constitution sets the 'ground rules' for the relationship between the Board and its members, as well as outlining the functions of the CCG and its constituent groups.

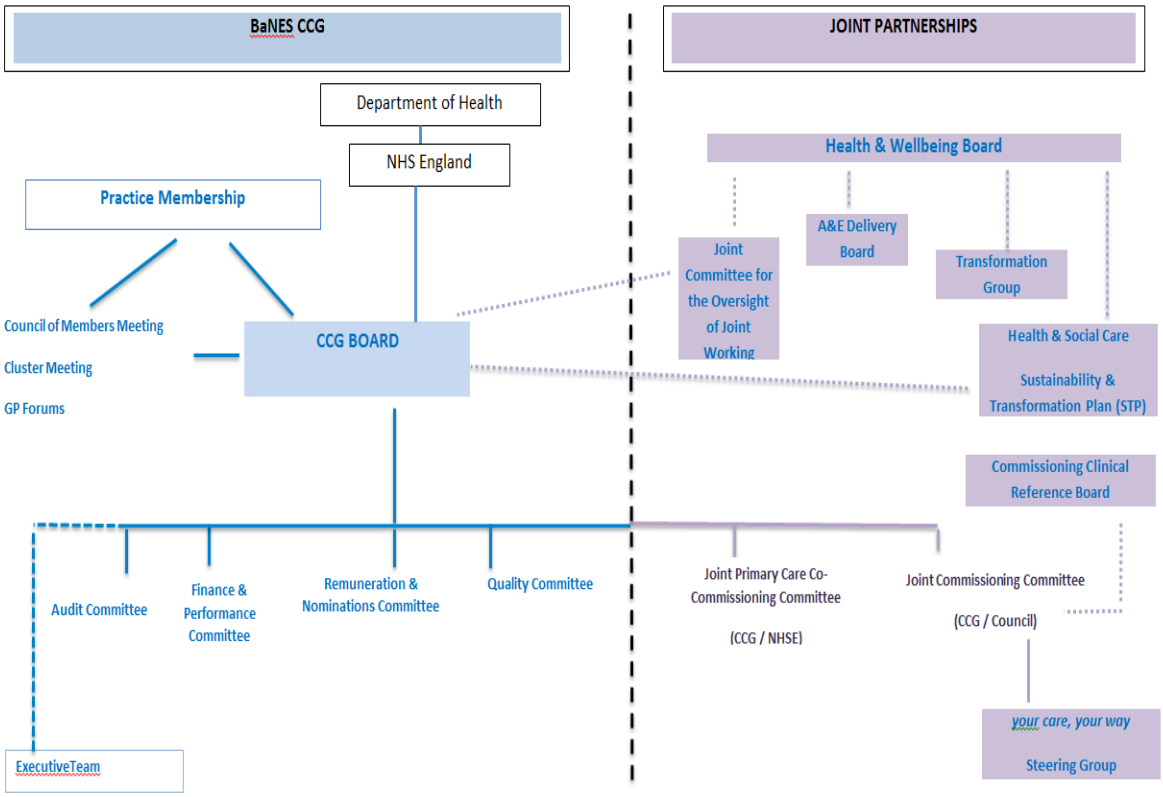
The Board is accountable to it Members via the Council of Members' meetings and the Cluster arrangements.

BaNES CCG Constitution is constructed around the exemplar model constitution provided by NHS England. During 2016/17 the Constitution was subject to amendment following engagement and consultation with member practices. These changes included:-

- The establishment of a Finance & Performance Committee
- Membership practice and representative changes
- A change to the composition of Board members to increase the number of lay members to three (effective from 1 April 2017).

These changes further strengthened the Constitution and governance structures (see diagram below) for the organisation. The Constitution includes the 'Scheme of Reservation and Delegation' which 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

CCG's Governance Structure



Council of 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 26 GP practices (as outlined on page 46) in B&NES, within four clusters. Each practice elects a GP to sit on our Council of Members. This group meets at least 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.

Council of Members performance and effectiveness

The Council of Members is chaired by the Clinical Chair of the CCG. In 2016/17 the Council of Members met on three occasions and held four ballots as follows:-

Meetings/Votes		
Date	***Item***	***Action***
Meeting - 17 May 2016	Presentation of Annual Report & Accounts 2015/16	Delegated authority for the CCG Board to approve on recommendation of the Audit Committee
Electronic Vote - September 2016	Vote : To change the CCG's Constitution to support Primary Care Fully Delegated Commissioning	Approved
Meeting – 15 November 2016	Presentation of Operational Plan 2017/19	None
Meeting – 15 December 2016	Final presentation of Operational Plan 2017/19	Approved Operational Plan 2017/19
Electronic Vote - December 2016	Vote : Election of 4 Board members	Re-appointment of Chair, Medical Director and Practice Manager representative Appointment of Dr Tim Sephton as GP representative from 1 April 2017

Attendance at meetings during 2016/17 was in the range of 95-97 per cent.

The CCG Board

The 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.

The 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 Board reviews its terms of reference for itself and its committees annually. It last updated its terms of reference in March 2017.

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 outlined on page 54. In May 2016 a further sub-committee was established to provide a robust performance framework which proactively managed the CCG's financial, performance and improving value schemes. The Committee was named Finance & Performance Committee.

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

The Board's performance and effectiveness

Board performance

The clinical leadership of the organisation has continued to develop. Following a robust election process in October-December 2017 the Chair, Medical Director and Practice Manager representative were all reappointed, with a new appointment of Dr Tim Sephton as GP Cluster Lead, effective from 1 April 2017.

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.

The Board met six times in public during the year. 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 2016/17 commissioning plans, financial matters, capacity and succession planning, procurement decisions, future strategic approach and safeguarding. All our Board meetings held in public papers are published on our website.

Attendance at Board meetings and Board Seminars in 2016/17 was as follows:-

Member	Number of Meetings Attended
Dr Ian Orpen (Chair)	11/12
Tracey Cox	10/12
Dr Ruth Grabham	11/12
Dawn Clarke	11/12
Sarah James	8/12
Dr James Hampton	9/12
Dr Elizabeth Hersch	11/12
Dr Daisy Curling (Mat leave from Sept 2016 to March 2017)	5/5
Dr Jonathan Osborn	12/12
Helen Harris	8/12
Myles Taylor	6/12
Suzannah Power	10/12
John Holden	12/12

There was also a successful and well attended Annual General Meeting held in September 2016 at which we presented our Annual Report and Accounts for 2015/16.

Key Areas of Board Activity 2016/17

The Governing Body has performed well throughout the year, providing clear strategic leadership and accountability for the organisations' business and activities. It has clear governance arrangements in place, with oversight from the Chair and the Audit Committee. Key activity for the Board in 2016/17 is outlined in the table below, however the key decision in 2016/17 was the joint decision with B&NES Council on the provision of community health and social care services. This followed extensive consultation with local people and a rigorous procurement process over a two year period and Virgin Care became the prime provider of these services on 1 April 2017.

The ongoing monthly 'informal' seminar sessions have provided an important opportunity for greater discussion and debate on matters of policy and strategy, directly informing and shaping the formal business of the organisation. Particular focus in 2016/17 was future strategic approach and risk appetite in the context of growing financial pressures faced the CCG and the current system of commissioning and providing health changing.

At each Board meeting that are set standard business items as below:-

Standard Business Items		
Chair's Report	Integrated Quality & Performance Report	Risk Register
Chief Officer's Report	Finance & QIPP Report	Declarations of Interests
Your Health, Your Voice Report	Quality Assurance Visits / Patient Story	Questions from the Public
Board Sub Committee Reports		

Other key Board activities during 2016/17 are outlined in the table below:

Strategy and Development	**Quality – Patient Safety, Effectiveness & Experience**	**Governance**
• Annual Commissioning Intentions • Sustainability and Transformation Plan (STP) • Staff Survey Results • Local Digital Roadmap • Organisational Development Plan • Emergency Preparedness, Resilience and Response (EPRR) Update • *'your care your way'* Full Business Case • Winter Resilience Plans 2016/17 • Risk Management Strategy • Annual Director of Public Health Report & Health Protection Report • Sustainable Development Management Plan • Estates Strategy	• Maternity Update following Morecambe Bay Review • Individual Funding Review Annual Report • Child & Adults Safeguarding • Annual Report • Compliments Concerns & Complaints Annual Report	• Equality & Diversity Annual Report • Revised Statutory Guidance on Conflicts of Interest • Review of Constitution

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

As part of the Board's continual evaluation, in 2016/17 Board members completed a skills mix self-assessment and at a Board Seminar in October 2016 considered the outcomes.

Building on the Board skills mix self-assessment one of the outcomes was to understand the roles and responsibilities of the Board, in particular clinical added value. This was discussed in depth at the December 2016 Board Seminar.
In summary the Board review insight for 2016/17 was:-

- Overall the Board was considered strong, bringing a good balance and mix of expertise and experience
- Progress had been made against the 2015/16 self-evaluation action plan
- Further development in 2017/18 would focus on the Board agenda by way of format and content particularly around the clinical added value element and Board training in specific areas.

The performance of individual members of the Board was undertaken by an appraisal process agreed by the Nominations Committee and these were carried out in 2016 as follows:-

- The Chair completed a 360^{o} survey and was also appraised by the lay members
- The lay members, Chief Officer and Medical Director were appraised by the Chair
- The GP representatives and Practice Manager were appraised by the Medical Director
- The Executive members were appraised by the Chief Officer

Objectives are set for each person alongside agreement as to any developmental needs, with full records of the appraisal meetings made and retained.

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 majority of CCG Board sub-committees are chaired by a lay member, the exceptions are Joint Commissioning Committee and Finance & Performance Committee.

The Board's Sub-Committees

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. During 2016/17 the Committee also took on the functions of an Auditor Panel in respect of the appointment of external auditors from 1 April 2017.

The membership of the Audit Committee in 2016/17 was as follows:-

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

Attendance at Audit Committee meetings in 2016/17 was as follows:-

Member	Number of Meetings Attended
John Holden (Chair)	5/5
Suzannah Power	5/5
Katie Hall	5/5
Tracey Cox *	3/5
Dawn Clarke *	5/5
Sarah James *	5/5

*** indicates regular attendance**

During the year the committee has continued to play an important role in the continued oversight and assurance of the CCG's governance arrangements and internal systems of control. This has included the setting and review of the annual internal audit cycle, local counter fraud and security management activities and the continued development of effective working relationships with the appointed internal and external auditors. The significant areas of activity by the Audit Committee during the year are listed in the table below:-

• Continued focus on the audit, assurance and risk processes within the organisation
• Reviewed the organisation's system of internal control and risk management, and any changes in accounting policies and impact on our financial statements
• Reviewed the Board Assurance Framework
• Reviewed the re-design and scope of the risk register, with particular focus on key strategic priorities
• Reviewed findings of internal audit reports: NHS Continuing Health Care, Acute Contract Management, QIPP Planning 2016/17, High Cost Drugs, Cyber Security, Financial Systems and Processes, Risk Management and Pooled Budgets
• Reviewed action plans to reflect the new guidance for CCGs on Conflicts of Interest
• Received and agreed work plans for internal and external audit, counter fraud and security management services.

The Audit Committee terms of reference were reviewed in April and October 2016 and the committee completed an annual self-assessment in May 2016.

Remuneration Committee

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.

Membership of the Remuneration Committee in 2016/17 was:-

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)

During 2016/17 one formal virtual meeting of the CCG Remuneration Committee was held.

The attendance at the Remuneration Committee for 2016/17 was:-

Member	Number of Meetings Attended
John Holden (Chair)	1/1
Suzannah Power	1/1
Dr Ian Orpen	1/1

Quality Committee

This committee is responsible for overseeing quality and safety processes across all commissioned services, ensuring alignment with delivery of the NHS Outcomes Framework and for assuring the Board that quality and patient safety activity is co-ordinated and transparent ensuring a coherent and systematic review of the system. The members of the Quality Committee during 2016/17 were:-

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	

Attendance at Quality Committee in 2016/17 was as follows:-

Member	Number of Meetings Attended
Suzannah Power (Chair)	6/6
Dawn Clarke	5/6
Dr Ruth Grabham	4/6
Dr Daisy Curling*	3/3
Tracey Cox	4/6
John Holden	6/6
Dr Jim Hampton*	2/3

*Dr Daisy Curling on maternity leave from September 2016 and Dr Jim Hampton covering from October 2016 onwards.

During 2016/17, the committee has made an important contribution to improving patient safety and outcomes; including the continued oversight of providers being held to account where Regulatory Inspection has found issues of concern or failure

to meet expected quality and/or safety standards. The committee has also reviewed safeguarding policy and training, examined patient transport processes and provided the necessary oversight for a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness, patient experience and safeguarding. Its Terms of Reference were reviewed in February 2017.

Joint Commissioning Committee

The Joint Commissioning Committee strengthens our partnership arrangements with the Council.

The Joint Commissioning Committee membership in 2016/17 was:-

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 (to July 2016)	Strategic Director for People & Communities
Mike Bowden (from August 2016)	Strategic Director for People & Communities
Jane Shayler	Director, Integrated Health & Care Commissioning (BaNES CCG & B&NES Council)
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:-

Clinical	**Joint Commissioning**	**Joint Business**
• MSK Services and policies • Emergency Stoke	• Direct Payment, Personal Health Budgets & Integrated	• Organisational Development Plan • Sustainable

Services in SW • Community care models; gastroenterology and dermatology, and pain management • Referral Support Service (RSS) • Adult Mental Health & Social Care Commissioning Strategy • Children and Adolescent Mental Health Services • Children with Special Education Needs and Disabilities (SEND) Implementation • Individual Funding Review Report and Policies • Medicine Management Policies • your care your way Business Case • Vasectomy Service	Personal Commissioning • Talking Therapies service • Better Care Fund Plans • Health Inequalities • Non-Emergency Patient Transport service	Development Management Plans • Annual Public Health and Health Prevention Annual Report • Planning & Contracting • Council's Strategic Transport Review

Attendance at the Joint Commissioning Committee in 2016/17 was:-

Member	Number of Meetings Attended
Tracey Cox	10/11
Sarah James	11/11
Dr Ruth Grabham	9/11
Dawn Clarke	9/11
Dr Daisy Curling	2/5
Dr Liz Hersch	8/11
Dr Jim Hampton	10/11
Dr Jonathan Osborn	10/11
Helen Harris	9/11

The terms of reference for the Joint Commissioning Committee were reviewed in March 2017.

Joint Primary Care Co-Commissioning Committee (JPCCC)
Membership of the Joint Primary Care Co-Commissioning in 2016/17 was 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

Attendance at the Joint Primary Care Co-Commissioning Committee in 2016/17 was:-

Member	Number of Meetings Attended
Suzannah Power – Chair	5/5
Dawn Clarke	4/5
Dr Ruth Grabham	4/5
Helen Harris	4/5
John Holden	5/5
Sarah James	4/5
Katie Hall	5/5

The Joint Primary Care Co-Commissioning Committee supports joint arrangements between our CCG and NHS England (NHSE) in the commissioning and designing of primary care services.

The BaNES CCG and NHS England Joint Primary Care Commissioning Committee 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 five occasions during 2016/17.

A number of standard reports are presented at each meeting which includes operations, local medical council, patient public engagement, quality and finance. Significant areas of business discussed by the JPCCC during 2016/17 were delegated commissioning, vulnerable practice scheme, management of conflicts of interest and the GP Forward View.

In November 2016, the CCG successfully applied to move to fully delegated and from 1 April 2017 the Joint Primary Care Co-Commissioning Committee will cease and become the Primary Care Commissioning Committee to reflect this change.

Finance & Performance Committee

This was a newly established Board sub-committee for 2016 and was formed to provide a robust performance framework which proactively manages the CCG's financial, performance and improving value schemes.

The membership of the Finance & Performance Committee for 2016/17 was:-

Finance & Performance Committee Members (voting)	
Dr Ian Orpen (Chair)	Clinical Chair
Tracey Cox	Chief Officer
Sarah James	Chief Financial Officer
Dr Ruth Grabham	Medical Director
Dawn Clarke	Director of Nursing & Quality / Registered Nurse
John Holden	Lay Member (Audit & Governance)
Corinne Edwards	Head of Commissioning Development
Julie-Anne Wales	Head of Corporate Governance & Planning
Jane Shayler	Director, Integrated Health & Care Commissioning

Attendance at the Finance & Performance Committee in 2016/17 was:-

Member	Number of Meetings Attended
Dr Ian Orpen (Chair)	6/9
Tracey Cox	8/9
Sarah James	7/9
Dr Ruth Grabham	6/9
Dawn Clarke	7/9
John Holden	7/9
Julie-Anne Wales	5/9
Jane Shayler	5/9

The first meeting took place in May 2016 and the key significant areas of business discussed by the Finance & Performance Committee during 2016/17 were the improving value schemes, financial position, budgets, NHS constitutional targets, planning/contracting round, operational plan, cash position, reserves and investment.

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, outlined in the Health & Wellbeing Strategy 2015-2019 which can be accessed through the following link: http://www.bathnes.gov.uk/sites/default/files/banes_health_and_wellbeing_strategy_2015_-_2019.pdf.

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 was 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.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

Discharge of Statutory Functions

In light of recommendations of the 1983 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative

requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

The risk and control framework encompasses the key assurance systems including planning, performance monitoring, audit, management policies and procedures, external assessment and assurance 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 last year 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 was undertaken 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 2016/17 there were no significant actions outstanding, although it was noted that the environment in which we are operating has become increasingly challenging.

We have updated our risk management strategy in 2016/17 to include a statement regarding our risk appetite. The 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 and risk management objectives; risk management framework and approach; roles and responsibilities; risk management process; risk identification, assessment and measurement; risk appetite and risk reporting and monitoring. To support the updated strategy, we have strengthened the role of the Executive Team in reviewing new risks and providing consistency in the scoring of risks.

A system of counter fraud has been in operation throughout 2016/17. 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 fair recruitment.
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.

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 previously audited with positive assurance provided.

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 Audit Committee and the CCG Board reviewed the assurance framework during 2016/17 and the framework was audited by the internal auditors last year 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 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 2016/17 were: improve performance against NHS constitutional targets; deliver next phase of your care your way; develop plans to transform primary care; work with the council to see how we can join up health and social care commissioning; service redesign and improving value programme; deliver agreed plans for mental health and learning disabilities service; deliver quality improvements and develop a Sustainability and Transformation Plan with partners in Wiltshire and Swindon.

The CCG has an organisation-wide risk register which is a Partnership Risk Register with the Council that covers the risks identified across the responsibilities of the CCG and where we have established joint commissioning arrangements with the Council. The register also provides risk mapping and 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 Executive Team also reviews all new risks before they are added to the register and reviews the whole risk register on a quarterly basis. Our statement regarding risk appetite states that risks with a score below 8 will be managed by individuals and not entered on the risk register unless they escalate. 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 Executive Team, Board, 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 2016/17 identified the key risks during this period as:

- Maintaining financial stability and delivery of financial targets;
- Mobilising and generating capacity to deliver Improving Value programmes at pace;

- Recovering emergency department access times and maintaining throughout the year;
- Recovering referral to treatment access times and maintaining;
- Creating an adequate transformation fund in 2016/17 to accelerate delivery.

Our risk profile has increased during 2016/17 with nine high scoring risks on the corporate risk register in May 2016. However, with the implementation of the new risk management strategy and the resulting review and rationalisation of the risk register and consistent application of risk scores, the number of corporate risks reduced to five risks by March 2017.

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, CHC high cost packages of care and re-procurement of commissioning support services. Later in the year, risks have emerged associated with cost pressures, transitioning to a new community services provider and primary care delegated commissioning and the risk to our financial surplus target with concerns about our financial position in 2017/18.

Other sources of assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group 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.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2016) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

The CCG has carried out an internal audit of conflicts of interest and the provisional outcome of the audit provides significant assurance with minor improvement opportunities.

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. A report describing the current process and key areas was taken to the Audit Committee during 2016/17.

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 have developed 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. Our most recent submission of the IG toolkit was scored as level 2.

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

We received assurance in respect of commissioning support functions via full access to their service auditor reports. Our CSU has a dedicated IT Security manager in post to safeguard the tools and technologies relied upon. An Information Security work plan has been developed for 2017/18 informed by CCG internal audit.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, we confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

There has been an audit during the year by Deloitte of service functions provided by the CSU up to 31 August 2016. It is not considered that any of these audit findings represent any significant control issues.

Control Issues

The control issues currently facing the CCG are as follows:

Control Issues	**Action**
Meeting NHS Constitutional Targets : 4 hours	A&E Delivery Board in place with System Improvement Plan encompassing national rapid implementation guidance to improve four hour performance

	Quality assurance arrangements in place via Clinical Quality Review meetings for patients experiencing A&E and Referral to Treatment (RTT) waits
Meeting NHS Constitutional Targets : RTT	Recovery plans in place for RTT monitored via Tripartite process Quality assurance arrangements in place via Clinical Quality Review meetings for patients experiencing A&E and Referral to Treatment (RTT) waits
Meeting NHS Constitutional Targets : Breast 2 week wait	Recovery plan for breast 2 week waits in place - delivered early - performance on track
Meeting NHS Constitutional Targets : Cancer 62 day screening	Recovery plan in place
Meeting NHS Constitutional Targets : Diagnostics -	Recovery plans in place with providers
Meeting NHS Constitutional Targets : CDiff infections	A multi-agency Health Care Acquired Infections Collaborative in place identifying actions to reduce CDiff infections and reviewing lapses in care
Meeting NHS Constitutional Targets : Dementia diagnosis	Practice pharmacists have identified additional patients by re-running the search for patients on dementia drugs Practices also re-running Data Quality Tool to see if this identifies any further patients
Financial Performance relating to non-delivery of our target surplus in 2016/17 and the implications of this for future years financial recovery planning	Financial recovery plan in place
Improvement and Assessment Framework (IAF) – requires improvement status in Better Care domain and anticipation of requires improvement status for Sustainability	Work plan in place to secure required improvements.

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 & Performance Committee in 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.

Delegation of functions

The CCG has a service level agreement in place with South, Central and West Commissioning Support Unit for the provision of a range of services including: Procurement, Provider Performance Management, Health Intelligence Analytics, Human Resources, Health and Safety support, Freedom of Information Requests, Incident Reporting, Information Governance, IT Technology and Support, IT Programmes and Planning, Data Services management, GP Information Technology.

Counter fraud arrangements

The CCG has an accredited Local Counter Fraud Specialist who produces and delivers a risk based work plan for the year, addressing each area of the Standards for Commissioners. This is agreed with the Chief Financial Officer, who has executive responsibility for tackling fraud, bribery and corruption, and approved by the Audit Committee. Progress against the work plan and any key issues arising from the work are reported to the Audit Committee through regular progress reports and an annual report, with regular information and planning meetings taking place with the Chief Financial Officer and other officers. There is proactive response to NHS Protect quality assurance recommendations and other good practice recommendations including those arising from local proactive and investigative work.

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 2016 to 31 March 2017 is that:

'significant with minor improvements 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 2016 to 31 March 2017 inclusive, and is based on the nine audits that we completed during 2016/17.

The design and operation of the Assurance Framework and associated processes

In accordance with our Internal Audit Plan for 2016-17, we have not undertaken a formal review of the Trust's Assurance framework during the year. However, we have completed a benchmarking exercise where the CCG Assurance Framework was compared to best practise. The CCG was consistent with the best practise in terms of risk reporting and framework layout, although there with some minor improvement opportunities such as distinguishing between internal and external factors and reporting of risk trajectory. Through observations at Audit Committee meetings, we have confirmed that the Assurance Framework is reviewed at each Committee and is provided to the Board for further discussion.

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 2016/17 assignments. For the other reviews we issued two reports with 'significant' assurance rating, five 'significant assurance with minor opportunities to improve' ratings, and two reports with 'partial assurance with improvement required' ratings related to Cyber Security and Financial Forecasting.

Two high priority recommendations have been raised during the year, both recommendations related to our review of Financial Forecasting and have been implemented by management.

Management have agreed action plans to address all recommendations raised during the year with one medium priority and one low priority recommendations noted as overdue.

This does not prevent us from issuing significant with minor improvements assurance. We do not consider the ratings and specifically, the detailed findings within these reviews, to impact on our overall opinion as the CCG has agreed action plans and is in the process of implementing these actions to mitigate the risks identified.

KPMG LLP Chartered Accountants Bristol

April 2017

During the year, Internal Audit issued the following audit reports:

Area of Audit	**Level of Assurance Given**
Acute Contract Management	Significant Assurance with minor improvement opportunities
QIPP Planning & Delivery	Significant Assurance with minor improvement opportunities
High Cost Drugs	Significant Assurance with minor improvement opportunities
Pooled Budgets Follow Up	Significant Assurance with minor improvement opportunities
Cyber Security & Business Continuity	Partial Assurance with improvement required
Conflicts of Interest	Significant Assurance with minor improvement opportunities
CHC Follow up	Significant Assurance
Financial Systems	Significant Assurance
Financial Forecasting	Partial Assurance with improvement required

The cyber security audit focussed on cyber risks and vulnerabilities through assessment against a cyber security maturity model. The audit made a range of recommendations covering staff awareness, information risk management, business continuity, technical solutions and maintaining legal compliance in this fast changing area. The resulting action plan runs to March 2018 with many actions already implemented.

In February 2017, the CCG identified a risk to the accuracy of forecasting. An internal audit was instigated to review the issue and to recommend actions to be undertaken to ensure the risk is managed through robust process and controls. These recommendations have been implemented.

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

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

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

I have reviewed the work of both the Audit and Quality Committees in discharging their responsibilities set out in the risk management strategy. The risk Management strategy has been updated in the current year and approved by the Board. This ensures that there is robust and regular monitoring of the adequacy of the effectiveness of the system of Internal Control throughout the year, which is reported to the Board on a regular basis. The updated strategy clarifies the roles of the newer committees of the Board: Finance and Performance Committee and the Joint Primary Care Co-Commissioning Committee and includes a statement regarding our risk appetite. This review highlights the CCG's commitment to securing continuous improvement of the system and the approach to identifying and addressing any weaknesses that have been identified and as such I confirm that the systems are currently effective. NHS England and the CCG are engaged in a process of continuous assessment against the CCG improvement and assessment framework 2016/17. This includes monthly discussions on performance issues, and the on-going work plan to provide assurance in the areas where performance improvement is required.

As part of this process, Executive Directors also attend risk based quarterly checkpoint reviews with NHSE. Our current self-assessment across the four domains is as follows: Better Health – Good; Better Care – Requires Improvement; Leadership – Good; and Sustainability – Requires Improvement. This rating relates predominantly to the difficulties in securing improvements in the delivery of NHS

Constitutional Targets across our local health system and to the non-delivery of our target surplus for 2016/17.. An Improvement Plan was submitted to NHS England to address.

Conclusion

Following completion of the planned audit work for the financial year for the CCG the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded that "significant assurance with minor improvements" can be given and that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

Signed:

Tracey Cox
Accountable Officer
25 May 2017

Remuneration Report

Remuneration Committee

Please see details of the Remuneration Committee in the Director's Report (page 67).

Policy on the remuneration of senior managers

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' (VSM) arrangements.

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 VSM 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 of 'very senior managers'

There are no senior managers of the CCG who are paid more than £142,500 per annum.

NHS Bath and North East Somerset Clinical Commissioning Group - remuneration of senior managers 2016-17 – (audited)

NHS Bath and North East Somerset Clinical Commissioning Group - remuneration of senior managers 2016-17 - 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	01/04/2016	Present	85-90	2	0	0	7.5-10	95-100
Dr Ruth Grabham, Medical Director	01/04/2016	Present	80-85	0	0	0	10-12.5	95-100
Tracey Cox, Chief Officer	01/04/2016	Present	80-85	1	0	0	70-72.5	190-195
Sarah James, Chief Financial Officer	01/04/2016	Present	90-95	2	0	0	0	90-95
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	01/04/2016	Present	85-90	1	0	0	17.5-20	100-105
Dr Elizabeth Hersch, GP Cluster Lead	01/04/2016	Present	25-30	0	0	0	5-7.5	30-35
Dr Daisy Curling, GP Cluster Lead	01/04/2016	Present	15-20	0	0	0	5-7.5	25-30
Dr James Hampton, GP Cluster Lead	01/04/2016	Present	25-30	0	0	0	N/A	25-30
Dr Jonathan Osborn, GP Cluster Lead	01/04/2016	Present	25-30	0	0	0	185-187.5	210-215
Mr Myles Taylor, Secondary Care Representative	01/04/2016	Present	5-10	0	0	0	N/A	5-10
Helen Harris, Practice Manager Representative	01/04/2016	Present	10-15	0	0	0	N/A	10-15
John Holden, Lay Member for Assurance and Governance	01/04/2016	Present	15-20	1	0	0	N/A	15-20
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2016	Present	15-20	2	0	0	N/A	15-20

Notes:

Dr James Hampton's costs for April to June 2016 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. From July 2016

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, Katie Hall and Suzannah Power

The CCG is unable to disclose pension details for Helen Harris and Mr Myles Taylor due to recharge arrangements. The CCG is not able to disclose pension details for Dr James Hampton as he is currently in receipt of a pension from the NHS Pensions Scheme.

The figures shown for Tracey Cox represent Tracey's total pay for the year including work for NHS Wiltshire CCG where she has been Chief Officer since 27th September 2016. A salary recharge in the banding of £35-40k (excluding employer's National Insurance and

The costs for Dr Ruth Grabham, 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.

All Gp's are now paid via payroll.

For comparison the table below shows remuneration for senior managers for 2015/16

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.

Pensions Disclosure - 2016 /17 – (audited)

NHS Bath & North East Somerset Clinical Commissioning Group - Audited

Pensions Disclosure - 2016 /17

Name and title	(a) Real increase in pension at pension age (bands of £2,500)	(b) Real increase in pension lump sum at pension age (bands of £2,500)	(c) Total accrued pension at pension age at 31 March 2016 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2016 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2016	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2017	(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	0-2.5	10-15	30-35	221	26	247	Nil
Dr Ruth Grabham, Medical Director	0-2.5	2.5-5	15-20	55-60	347	42	390	Nil
Tracey Cox, Chief Officer	5-7.5	7.5-10	40-45	110-115	549	63	640	Nil
Sarah James, Chief Financial Officer	0	0	30-35	90-95	554	0	554	Nil
Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member	0-2.5	2.5-5	20-25	60-65	405	39	444	Nil
Dr Elizabeth Hersch, GP Cluster Lead	0-2.5	0	5-10	20-25	132	14	146	Nil
Dr Daisy Curling, GP Cluster Lead	0-2.5	0-2.5	10-15	30-35	138	9	147	Nil
Dr Jonathan Osborn, GP Cluster Lead	7.5-10	22.5-25	10-15	35-40	67	129	196	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 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 figures for Dr Jonathon Osborn show the increase since any period of previous officer work, which may have been a number of years previously.

No additional benefits are payable to a senior manager in the event they retire early.

For comparison the table below shows pensions for senior managers for 2015/16

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.

Cash equivalent transfer values

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their 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.

Compensation on early retirement for loss of office (audited)

There was one senior manager who took early retirement in 2016/17 due to ill health. The total amount was £15,523.10.

Payments to past members

During 2016/17 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.

Multiple Pay 2016/17

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 2016-17 was £85,000 - £90,000 (2015-16: £85,000 - £90,000). Based on a whole time equivalent this salary was in the band of £150,000-£155,000 (2015-16: £150,000 - £155,000). This was 3.69

(2014-15: 3.65) times the median remuneration of the remainder of the workforce, which was £41,373 (2015-16: £41,788).

In 2016/17, 1 (2015/16: 0) employee received remuneration in excess of the highest paid director / member in NHS Bath and North East Somerset CCG in whole-time equivalent terms. This employee had a whole-time equivalent salary in the band of £150,000-£155,000. This relates to a clinical employee working one session per week at an actual cost in the band £15,000-£20,000. The individual worked for the CCG on the same terms in 2015/16 but was paid through a recharge mechanism so was not then classed as an employee.

Full-time equivalent remuneration ranged from £16,000 to £155,000 (2015-16: £15,000 to £150,000).

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

Signed:

Tracey Cox
Accountable Officer
25 May 2017

Staff Report

Number of senior managers

The number of senior managers by band:		
Band	**Headcount**	**FTE**
8a	10	7.79
8b	9	7.20
8c	7	6.08
8d	2	2.00
other	13	5.56

Staff numbers and costs – (audited)

Recoveries in respect of employee benefits	**2016-17**			**2015-16**
	Total	**Permanent Employees**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Employee Benefits - Revenue				
Salaries and wages	(348)	(255)	(93)	(205)
Social security costs	(26)	(26)	0	(20)
Employer contributions to the NHS Pension Scheme	(33)	(33)	0	(29)
Termination benefits	(18)	(18)	0	0
Total recoveries in respect of employee benefits	**(425)**	**(332)**	**(93)**	**(254)**

Employee benefits	2016-17	Total			Admin			Programme	
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	3,131	2,625	507	2,189	1,906	283	943	719	223
Social security costs	313	283	30	241	212	30	72	71	1
Employer Contributions to NHS Pension scheme	354	350	4	262	258	4	92	92	1
Termination benefits	24	24	0	24	24	0	0	0	0
Gross employee benefits expenditure	**3,822**	**3,281**	**541**	**2,716**	**2,399**	**317**	**1,107**	**882**	**225**
Less recoveries in respect of employee benefits	(425)	(332)	(93)	(318)	(316)	(2)	(107)	(16)	(91)
Total - Net admin employee benefits including capitalised costs	**3,398**	**2,949**	**448**	**2,398**	**2,083**	**315**	**1,000**	**866**	**133**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**3,398**	**2,949**	**448**	**2,398**	**2,083**	**315**	**1,000**	**866**	**133**

Employee benefits	2015-16	Total			Admin			Programme	
	Total	Permanent Employees	Other	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits									
Salaries and wages	2,709	2,320	389	2,014	1,711	303	695	610	86
Social security costs	204	202	3	153	153	(0)	52	49	3
Employer Contributions to NHS Pension scheme	336	316	20	249	232	16	87	83	4
Gross employee benefits expenditure	**3,249**	**2,838**	**412**	**2,415**	**2,096**	**319**	**834**	**741**	**93**
Less recoveries in respect of employee benefits	(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**

Average number of people employed

	2016-17			2015-16
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**65**	**57**	**8**	**57**

There are no people engaged on capital projects in either 2015-16 or 2016-17

The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the number of weeks in the financial year.

Staff Composition – as at 31 March 2017

The CCG currently employs 76 (61.64 FTE) staff comprising:-				Board Members	
Gender	**Part Time**	**Full Time**	**Total**	**VSM***	**Others**
Female	30	30	60	3	5
Male	6	10	16	0	5
An overall increase of eleven from previous year. This is due to replacing interim with permanent staff, moving previously recharged staff on to the payroll to ensure correct treatment of tax and NI. Also employing staff on behalf of joint arrangements eg with the Council or STP, with contributions to cost received from other parties.					

*There are no other “Very Senior Managers” (VSM) within the organisation

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.

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

For 2016/17 the spend on Consultancy services (Note 6 of the Annual Accounts) is £5k, which consists of £2k for VAT consultancy services (2015/16 £2k restated) and £3k on external review of off-payroll arrangements (2015/16 £Nil).
The CCG's external auditor, Grant Thornton, were paid £54k(Inc. VAT) for Audit Services in the reporting year 2016/17 relating to statutory audit work carried out. These statutory services include both the audit of the CCG's financial statements and related reporting, and other statutory activities such as value for money work.

Off-payroll engagements

Off-Payroll Disclosure - 2016-17:

Table 1:

For all off-payroll engagements as of 31 March 2017, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as of 31st March 2017	5
Of which, the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	1
For between 2 and 3 years at the time of reporting	1
For between 3 and 4 years at the time of reporting	1

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.

Table 2:

For all new off-payroll engagements between 1 April 2016 and 31 March 2017, 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 2016 and 31 March 2017	3
Number of new engagements which include contractual clauses giving NHS Bath and North East Somerset Clinical Commissioning Group the right to request assurance in relation to income tax and National Insurance obligations	3
Number for whom assurance has been requested	3
Of which:	
assurance has been received	3
assurance has not been received	0
engagements terminated as a result of assurance not being received	0

Table 3:

For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017:

Number of off-payroll engagements of board members and / or senior officers with significant financial responsibility, during the financial year	2
Total number of individuals on payroll and off-payroll that have been deemed "board members, and / or senior officers with significant financial responsibility" during the financial year.	13

The two board members who were paid through off-payroll arrangements are Dr James Hampton (April - June) and Helen Harris who were paid via their GP practice's payroll (St Michael's Surgery and Number 18 Surgery respectively) and recharged to the CCG. From July 2016 onwards, Dr James Hampton was paid via payroll.
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, including special (non-contractual) payments – (audited)

Exit Packages agreed in the financial year

	2016/17			2015/16		
	Compulsory redundancies number	Other agreed departures number	Total number	Compulsory redundancies number	Other agreed departures number	Total number
Less than £10,000	0	1	1	0	0	0
£10,001 to £25,000	0	1	1	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**2**	**2**	**0**	**0**	**0**
Total cost (£'000)	**0**	**21**	**21**	**0**	**0**	**0**

Analysis of other departures in the financial year

	2016/17		2015/16	
	Other Agreed Departures		Other Agreed Departures	
	Number	£'000	Number	£'000
Contractual payment in lieu of notice	2	18	0	0
Non-contractual payments requiring HM Treasury approval	1	3	0	0
Total	**3**	**21**	**0**	**0**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number of exit packages will not necessarily match the total number in the preceding table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

The non-contractual payment requiring HM Treasury approval was pending approval as at the reporting date but has been accrued into the 2016-17 accounts on the advice of the CCG's solicitors. The CCG awaits formal confirmation from HM Treasury before payment is made.

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme and are included in the tables. Ill health retirement costs are met by the NHS Pension Scheme and are not included in the tables above.

Signed:

Tracey Cox
Accountable Officer
25 May 2017

Parliamentary Accountability and Audit Report

Bath & North East Somerset CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An audit certificate and report is also included in this Annual Report.

Signed:

Tracey Cox
Accountable Officer
25 May 2017

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 (B&NES) CCG for the year ended 31 March 2017 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, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 (the "2016/17 GAM") and the requirements of the Health and Social Care Act 2012.

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

- the single total figure of remuneration for each director on page 87;
- CETV disclosures for each director on page 89;
- the table of exit packages and related narrative notes on page 98;
- the analysis of staff numbers and costs on page 93; and
- the table of fair pay (pay multiples) disclosures on page 91.

This report is made solely to the members of the Governing Body of B&NES 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 Chief Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Chief 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, the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") 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 as required by the Act.

As explained in the Governance Statement the Chief 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 by exception where we are not satisfied.

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria issued by the Comptroller and Auditor General in November 2016, 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 2017, 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.

Opinion on financial statements

In our opinion:

- the financial statements give a true and fair view of the financial position of B&NES as at 31 March 2017 and of its expenditure and income for the year then ended; and
- the financial statements have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012.

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 Accountability Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health Group Accounting Manual 2016/17 and the requirements of the Health and Social Care Act 2012; and
- the other information published together with the audited financial statements in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the audited financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the Corporate Governance Report does not comply with the guidance issued by the NHS Commissioning Board; or
- we have referred a matter to the Secretary of State under section 30 of the Act because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have reported a matter in the public interest under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have made a written recommendation to the CCG under section 24 of the Act in the course of, or at the conclusion of the audit; or
- we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Certificate

We certify that we have completed the audit of the financial statements of B&NES CCG in accordance with the requirements of the Act and the Code of Audit Practice.

[Signature]

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

Hartwell House
55-61 Victoria Street
Bristol BS1 6FT

[DATE]

Section 3
Annual Accounts

Signed :

Sarah James
Chief Financial Officer
25 May 2017

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31st March 2017 1
Statement of Financial Position as at 31st March 2017 2
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2017 3
Statement of Cash Flows for the year ended 31st March 2017 4

Notes to the Accounts

1 Accounting policies 5-9
2 Financial performance targets 9
3 Other operating revenue 9
4 Revenue 10
5 Employee benefits and staff numbers 10-12
6 Operating expenses 12
7 Better payment practice code 12
8 Finance costs 13
9 Operating leases 13
10 Trade and other receivables 14
11 Cash and cash equivalents 14
12 Trade and other payables 15
13 Provisions 16
14 Other Financial Commitments 16
15 Financial instruments 17
16 Operating segments 18
17 Pooled budgets 18
18 Related party transactions 19
19 Events after the end of the reporting period 19
20 Losses and special payments 19

Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	3	(1,064)	(969)
Other operating income	3	(537)	(961)
Total operating income		**(1,601)**	**(1,930)**
Staff costs	5	3,822	3,249
Purchase of goods and services	6	228,544	223,046
Depreciation and impairment charges		0	0
Provision expense	6	411	(218)
Other Operating Expenditure[1]	6	155	648
Total operating expenditure		**232,932**	**226,726**
Net Operating Expenditure		**231,331**	**224,796**
Finance expense	8	1	0
Total Net Expenditure for the year		**231,333**	**224,796**
Comprehensive Expenditure for the year ended 31 March 2017		**231,333**	**224,796**

[1]Other Operating expenditure consists of Chair and Non executive costs (£151k) and Clinical negligence costs (£4k). 2015-16 prior year included Grants to other bodies of (£473k), and Research and Development costs (£22K).

The notes on pages 5 to 19 form part of this statement

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Current assets:			
Trade and other receivables	10	1,436	856
Cash and cash equivalents	11	169	197
Total current assets		**1,605**	1,053
Total assets		**1,605**	1,053
Current liabilities			
Trade and other payables	12	(12,368)	(11,973)
Provisions	13	(411)	0
Total current liabilities		**(12,778)**	(11,973)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(11,173)**	(10,920)
Total non-current liabilities		**0**	0
Assets less Liabilities		**(11,173)**	(10,920)
Financed by Taxpayers' Equity			
General fund		(11,173)	(10,920)
Total taxpayers' equity:		**(11,173)**	(10,920)

The notes on pages 5 to 19 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 25th May 2017 and signed on its behalf by

Signed :

Sarah James
Chief Financial Officer
25 May 2017

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(10,920)**	0	0	**(10,920)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating expenditure for the financial year	(231,333)			(231,333)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(242,253)**	**0**	**0**	**(242,253)**
Net funding	231,080	0	0	231,080
Balance at 31 March 2017	**(11,173)**	**0**	**0**	**(11,173)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(11,167)**	**0**	**0**	**(11,167)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(224,796)			(224,796)
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(235,964)**	**0**	**0**	**(235,964)**
Net funding	225,043	0	0	225,043
Balance at 31 March 2016	**(10,920)**	**0**	**0**	**(10,920)**

The notes on pages 5 to 19 form part of this statement

Statement of Cash Flows for the year ended
31 March 2017

	Note	**2016-17** **£'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(231,333)	(224,796)
(Increase)/decrease in trade & other receivables	10	(580)	1,077
Increase/(decrease) in trade & other payables	12	394	(1,013)
Increase/(decrease) in provisions	13	411	(218)
Net Cash Outflow from Operating Activities		**(231,107)**	(224,950)
Net Cash Outflow from Investing Activities		**0**	0
Net Cash Inflow (Outflow) before Financing		**(231,107)**	(224,949)
Cash Flows from Financing Activities			
Parliamentary Funding Received		231,080	225,043
Net Cash Inflow (Outflow) from Financing Activities		**231,080**	225,043
Net Decrease in Cash & Cash Equivalents	11	**(28)**	93
Cash & Cash Equivalents at the Beginning of the Financial Year		**197**	104
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		**169**	197

The notes on pages 5 to 19 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. The accounting policies contained in the Group Accounting Manual 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 Group Accounting Manual 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 and 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 agreed a final expenditure amount with the Royal United Hospital NHS Foundation Trust (RUH). The accounts contain accruals which are £468k higher than those included in the accounts of the RUH to reflect the Clinical Commissioning Group's view of higher activity levels incurred in March.

Notes to the financial statements

1.5 **Revenue**

The main source of funding for the Clinical Commissioning Group is allocations (Parliamentary Funding) from the Department of Health within an approved cash limit, which is credited to the General Fund of the Clinical Commissioning Group. Parliamentary funding is recognised in the financial period in which the cash is received.

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.

Notes to the financial statements

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.

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 introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme Clinical Commissioning Groups contributed annually in 2014-15, 2015-16, and 2016-17 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 2016-17 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 2016-17 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 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

1.19 **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).

1.20 **Subsidiaries**

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

1.21 **Associates**

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

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

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

1.24 **Research & Development**

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

1.25 **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 2016-17, all of which are subject to consultation:

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Financial performance targets

The NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended). Bath and North East Somerset Clinical Commissioning Group performance against those duties was as follows:

	2016-17 Target	2016-17 Performance	2016-17 Variance £'000	2016-17 Target Achieved?
Expenditure not to exceed income	**235,245**	**232,929**	**2,316**	**Yes**
Revenue resource use does not exceed the amount specified in Directions	**233,649**	**231,333**	**2,316**	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	**4,268**	**4,150**	**118**	**Yes**

NHS England set the Clinical Commissioning Group a Revenue Resource Limit of £233,649,000 for 2016-17, and the Clinical Commissioning Group achieved an underspend of £2,316,000 against this target. This included the headroom reserve for the year of £2,234,000 and £82,000 of underspend surplus. The Clinical Commissioning Group underspent by £118,000 on administration costs, against a target spend of no more than £4,268,000. Whilst we achieved a balanced final position by the end of 2016/17, we were not able to deliver the 1% surplus of £2.3m as required of us by NHS England. We met a further national requirement to hold 1% of our funding, known as headroom, and release this into our position at the end of the year. Therefore, of a final requirement to deliver a 2% surplus of £4.6m, we were able to achieve 1%, or £2.3m.

Performance in 2015-16 was as follows:

	2015-16 Target	2015-16 Performance	2015-16 Variance £'000	2015-16 Target Achieved?
Expenditure not to exceed income	228,973	226,726	2,247	**Yes**
Revenue resource use does not exceed the amount specified in Directions	227,043	224,796	2,247	**Yes**
Revenue administration resource use does not exceed the amount specified in Directions	4,707	3,717	990	**Yes**

NHS England set a Revenue Resource Limit of £227,043,000 for 2015-16, and the Clinical Commissioning Group achieved an underspend of £2,247,000 against this target. The Clinical Commissioning Group also underspent by £990,000 on administration costs, against the target spend of no more than £4,707,000 in 2015-16.

3 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	**425**	318	107	254
Prescription fees and charges	**0**	0	0	30
Charitable and other contributions to revenue expenditure: non-NHS	**0**	0	0	15
Non-patient care services to other bodies	**1,064**	110	954	969
Other revenue	**112**	11	101	661
Total other operating revenue	**1,601**	**438**	**1,163**	**1,930**

The 2015-16 figure for Other revenue included a one off receipt (£410k) of non-recurrent project funding .

4 Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	**1,600**	438	1,163	1,930
Total	**1,600**	**438**	**1,163**	**1,930**

5. Employee benefits and staff numbers

5.1.1 Employee benefits **2016-17** **Total**

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	3,131	2,625	507
Social security costs	313	283	30
Employer Contributions to NHS Pension scheme	354	350	4
Termination benefits	24	24	0
Gross employee benefits expenditure	**3,822**	**3,281**	**541**
Less recoveries in respect of employee benefits (note 5.1.2)	(425)	(332)	(93)
Total - Net admin employee benefits including capitalised costs	**3,398**	**2,949**	**448**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**3,398**	**2,949**	**448**

5.1.1 Employee benefits **2015-16** **Total**

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	2,709	2,320	389
Social security costs	204	202	3
Employer Contributions to NHS Pension scheme	336	316	20
Gross employee benefits expenditure	**3,249**	**2,838**	**412**
Less recoveries in respect of employee benefits (note 5.1.2)	(254)	(254)	0
Total - Net admin employee benefits including capitalised costs	**2,995**	**2,583**	**412**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**2,995**	**2,583**	**412**

5.1.2 Recoveries in respect of employee benefits **2016-17** **2015-16**

	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(348)	(255)	(93)	(205)
Social security costs	(26)	(26)	0	(20)
Employer contributions to the NHS Pension Scheme	(33)	(33)	0	(29)
Termination benefits	(18)	(18)	0	0
Total recoveries in respect of employee benefits	**(425)**	**(332)**	**(93)**	**(254)**

5.2 Average number of people employed

	Total Number	2016-17 Permanently employed Number	Other Number	2015-16 Total Number
Total	**65**	**57**	**8**	**57**

The material change in staffing costs between 2016/17 and 2015/16 is attributable to a decision by the Clinical Commissioning Group to work to full budgeted capacity to support delivery of our Operational Plan, whereas in previous years we have chosen to reduce expenditure costs in this area to contribute to our wider savings programme. This has been done by replacing interim with permanent staff, moving previously recharged staff on to the payroll to ensure correct treatment of tax and NI and employing staff on behalf of joint arrangements eg Council or STP, with contributions to cost received from other parties.
There are no people engaged on capital projects in either 2015-16 or 2016-17

5.3 Staff sickness absence and ill health retirements

	2016-17 Number	2015-16 Number
Total Days Lost[1]	266	181
Total Staff Years	55	50

Average working Days Lost	5	4

[1] Number of days lost includes ill health retirement cases

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	1	0

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

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	5,483	1	5,483
£10,001 to £25,000	0	0	1	15,523	1	15,523
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**2**	**21,006**	**2**	**21,006**

Analysis of Other Agreed Departures[1]

	2016-17 Other agreed departures		2015-16 Other agreed departures	
	Number	£	Number	£
Contractual payments in lieu of notice	2	18,267	0	0
Non-contractual payments requiring HMT approval	1	2,739	0	0
Total	**3**	**21,006**	**0**	**0**

[1]As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where the Clinical Commissioning Group has agreed early retirements, the additional costs are met by the Clinical Commissioning Group and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

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

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 2016-17, employers' contributions of £357,628 were payable to the NHS Pensions Scheme (2015-16: £328,469) at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the employee benefit lines of note 6.

6. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Gross employee benefits				
Employee benefits excluding governing body members	**3,480**	2,373	1,107	2,876
Executive governing body members	**342**	343	0	373
Total gross employee benefits	**3,822**	**2,716**	**1,107**	**3,249**
Other costs				
Services from other CCGs and NHS England	**1,706**	1,243	464	1,630
Services from foundation trusts	**101,100**	0	101,100	99,058
Services from other NHS trusts	**23,080**	0	23,080	22,712
Services from other WGA bodies	**143**	0	143	3
Purchase of healthcare from non-NHS bodies	**72,595**	0	72,595	70,420
Chair and Non Executive Members	**151**	151	0	149
Supplies and services – clinical	**919**	0	919	835
Supplies and services – general	**426**	72	354	130
Consultancy services	**5**	5	0	(10)
Establishment	**184**	112	72	188
Transport	**1**	1	0	3
Premises[1]	**239**	136	103	8
Audit fees	**54**	54	0	54
Prescribing costs	**25,436**	0	25,436	25,509
General ophthalmic services	**5**	0	5	8
GPMS/APMS and PCTMS	**2,321**	0	2,321	1,925
Other professional fees excl. audit	**58**	42	16	49
Grants to Other bodies[2]	**0**	0	0	473
Clinical negligence	**4**	4	0	5
Research and development (excluding staff costs)	**0**	0	0	22
Education and training	**70**	52	18	20
Provisions	**411**	0	411	(218)
CHC Risk Pool contributions[3]	**202**	0	202	504
Total other costs	**229,109**	**1,872**	**227,238**	**223,476**
Total operating expenses	**232,932**	**4,587**	**228,344**	**226,725**

[1]Premises costs in 2015-16 were lower 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 the previous year's charge. Full details are disclosed in note 9.1.1.

[2]In 2015-16, a one off capital to revenue grant was received to fund an equipment grant. This did not continue in 2016-17

[3]A provision has been made for CHC costs . Details are disclosed in note 13

7.1 Better Payment Practice Code

Measure of compliance	**2016-17 Number**	**2016-17 £'000**	2015-16 **Number**	2015-16 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	3,568	83,447	3,928	86,334
Total Non-NHS Trade Invoices paid within target	3,425	81,953	3,741	85,029
Percentage of Non-NHS Trade invoices paid within target	**95.99%**	**98.21%**	**95.24%**	**98.49%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,569	125,993	2,486	116,828
Total NHS Trade Invoices Paid within target	2,466	124,815	2,406	114,878
Percentage of NHS Trade Invoices paid within target	**95.99%**	**99.07%**	**96.78%**	**98.33%**

7.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2016-17 £'000**	2015-16 £'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. Finance costs

	2016-17 £'000	2015-16 £'000
Interest		
Interest on late payment of commercial debt	**0**	0
Interest expense to HMRC	**1**	0
Total interest	**1**	**0**
Total finance costs	**1**	**0**

9. Operating Leases

9.1 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 2016-17 are disclosed below:

9.1.1 Payments recognised as an Expense

The negative figure for buildings in 2015-16 arose 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 decreased and a number of vacant properties were disposed of by NHS Property Services Ltd reducing the costs to the point where the Clinical Commissioning Group received a rebate.

			2016-17			2015-16
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	56	2	**58**	(66)	2	**(64)**
Contingent rents	0	0	**0**	0	0	**0**
Sub-lease payments	0	0	**0**	0	0	**0**
Total	**56**	**2**	**58**	**(66)**	**2**	**(64)**

9.1.2 Future minimum lease payments

Whilst our arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charge for future

			2016-17			2015-16
	Buildings £'000	Other £'000	Total £'000	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	0	1	**1**	0	2	**2**
Between one and five years	0	0	**0**	0	1	**1**
After five years	0	0	**0**	0	0	**0**
Total	**0**	**0**	**0**	**0**	**3**	**3**

9.2 As lessor

The Clinical Commissioning Group has no operating leases as a lessor to report in 2016-17.

9.2.2 Future minimum rental value	2016-17 £'000	2015-16 £'000
Receivable:		
No later than one year	**1**	2
Between one and five years	**0**	1
After five years	**0**	0
Total	**1**	**3**

10 Trade and other receivables[1]	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	**223**	0	263	0
NHS prepayments[2]	**775**	0	69	0
NHS accrued income[3]	**0**	0	352	0
Non-NHS and Other WGA receivables: Revenue	**254**	0	57	0

Non-NHS and Other WGA prepayments	**194**	0	98	0
Non-NHS and Other WGA accrued income	**109**	0	13	0
Provision for the impairment of receivables	**(145)**	0	0	0
VAT	**26**	0	4	0
Total Trade & other receivables	**1,436**	**0**	**856**	**0**
Total current and non current	**1,436**		**856**	

[1]There are no prepaid Pension Contributions in the above receivables figures.

[2]£503k of the prepayments relate to Maternity payments made to the Royal United Hospitals (£383k) and University Hospitals Bristol (£120k) under the pathway tariff introduced from 1st April 2017.
[3]The 2015-16 figure related to underperformance by North Bristol NHS Trust calculated at the year end(£348k) and owed to the Clinical Commissioning Group.

10.1 Receivables past their due date but not impaired[1] [2]	**2016-17**	2015-16
	£'000	£'000
By up to three months	**218**	10
By three to six months	**70**	0
By more than six months	**13**	0
Total	**301**	**10**

[1]£5k of the amount above has subsequently been recovered post the statement of financial position date. The Clinical Commissioning Group continues to pursue the debts and remains confident of their recovery.

[2]The Clinical Commissioning Group does not hold any collateral against outstanding receivables at 31 March 2017 .

10.2 Provision for impairment of receivables[1]	**2016-17**	2015-16
	£'000	£'000
Balance at 01 April 2016	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	(145)	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**(145)**	**0**

[1]Receivables impaired relate to invoices raised to non-NHS providers in respect of a specific procedure which the Clinical Commissioning Group considers non-chargeable and which have been disputed.

11 Cash and cash equivalents

	2016-17	2015-16
	£'000	£'000
Balance at 01 April 2016	**197**	104
Net change in year	**(28)**	92
Balance at 31 March 2017	**169**	**197**
Made up of:		
Cash with the Government Banking Service	**169**	197
Cash and cash equivalents as in statement of financial position	**169**	**197**
Balance at 31 March 2017	**169**	**197**

The Clinical Commissioning Group does not hold any patients' monies.

12 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS payables: revenue	**1,611**	0	2,792	0
NHS accruals	**2,071**	0	562	0
NHS deferred income	**14**	0	16	0
Non-NHS and Other WGA payables: Revenue	**979**	0	2,913	0
Non-NHS and Other WGA accruals	**7,383**	0	5,522	0
Non-NHS and Other WGA deferred income	**0**	0	7	0
Social security costs	**43**	0	32	0
Tax	**39**	0	33	0
[1]Other payables and accruals	**228**	0	97	0

Total Trade & Other Payables	**12,368**	**0**	**11,973**	**0**
Total current and non-current	**12,368**		**11,973**	

[1]Other payables include £55k of outstanding pension contributions at 31 March 2017.

13 Provisions

	Current 2016-17 £'000	Non-current 2016-17 £'000	Current 2015-16 £'000	Non-current 2015-16 £'000
Continuing care	**411**	0	0	0
Total	**411**	**0**	**0**	**0**
Total current and non-current	**411**		**0**	

	Continuing Care £'000	Total £'000
Balance at 01 April 2016	**0**	**0**
Arising during the year	**411**	411
Utilised during the year	**0**	0
Reversed unused	**0**	0
Unwinding of discount	**0**	0
Change in discount rate	**0**	0
Balance at 31 March 2017	**411**	**411**
Expected timing of cash flows:		
Within one year	411	411
Between one and five years	0	0
After five years	0	0
Balance at 31 March 2017	**411**	**411**

Continuing Care - This provision relates to existing retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel. This provision has been based on certain specific claims plus an estimate for claims not yet considered by the panel and reflecting average activity over the last 3 years.

14 Other financial commitments

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

15 Financial instruments

15.1 Financial risk management

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

Because 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.

15.1.1 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

15.1.2 Interest rate risk

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

15.1.3 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.

15.1.4 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.

15 Financial Instruments cont'd
15.2 Financial assets

	Receivables 2016-17 £'000	Total 2016-17 £'000
Receivables:		
· NHS	**223**	223
· Non-NHS	**363**	363
Cash at bank and in hand	**169**	169
Total at 31 March 2017	**756**	**756**

	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**

15.3 Financial liabilities

	Other 2016-17 £'000	Total 2016-17 £'000
Payables:		
· NHS	**3,683**	3,683
· Non-NHS	**8,590**	8,590
Total at 31 March 2017	**12,273**	**12,273**

	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**

16 Operating segments

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

17 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, Better Care Fund and Community Equipment and 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	Better Care Fund
	£000	£000	£000	£000	£000
Gross Funding					
Bath & North East Somerset Council	**24,263**	203	2,516	20,044	1,500
Bath & North East Somerset Clinical Commissioning Group	**15,073**	473	392	5,663	8,545
Income from client contributions	**1,825**	0	0	1,825	0
Interest on External Funding Balances	**0**	0	0		0
Total Funding	**41,161**	676	2,908	27,532	10,045
Net overspend funded as detailed below					
Bath & North East Somerset Council	**1,934**	52	848	1,034	0
Bath & North East Somerset Clinical Commissioning Group	**570**	121	134	315	0
Total Overspend	**2,504**	173	982	1,349	0

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs was signed on 12 April 2017 and all the other accounts were signed on 24 April 2017 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:

	2016-17	2015-16
	£000	£000
Income	0	329
Expenditure	43,665	46,256

18 Related party transactions[1]

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	110	0	0	0
St Chad's Surgery	Dr Elizabeth Hersch	578	0	0	0
St James Surgery	Dr Ian Orpen	115	0	0	1
St Michaels Surgery	Dr James Hampton	145	0	0	0
Wiltshire CCG	Suzannah Power[2] & Tracey Cox[3]	2	41	3	8

[1]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.

[2]Suzannah Power has a family member who is a GP representative for Wiltshire CCG.
[3] Tracey Cox has been partially seconded to Wiltshire CCG since September 2016.

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 Hospitals Bath NHSFT
South West Ambulance NHSFT
University Hospitals 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.

19 Events after the end of the reporting period

Delegated Commissioning of Primary Medical Care 2017/18

NHS England recently announced details of the Clinical Commissioning Groups approved to take on greater delegated responsibility or to jointly commission GP services from 1st April 2017. The new Primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Bath and North East Somerset Clinical Commissioning Group has been approved under delegated commissioning arrangements which mean that the Clinical Commissioning Group will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1st April 2017.

20 Losses and special payments
The Clinical Commissioning Group has no losses to report in 2016-17.

	Total Number of Cases	**Total Value of Cases**	Total Number of Cases	Total Value of Cases
	2016-17 Number	**2016-17 £'000**	2015-16 Number	2015-16 £'000
Special severance payments	1	3	0	0
Total	**1**	**3**	**0**	**0**