NHS
Bath and
North East Somerset
Clinical Commissioning Group

# Annual Report and Accounts 2017/18

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

# PERFORMANCE REPORT

**Signed:**

**Tracey Cox**
**Accountable Officer**
24 May

# 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 practices in the region. 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 203,912 patients (October 2017) versus 187,751 residents (2016 figures). In 2017/18 our budget was £257 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 2017/18 with reference to the services we commission.

## Chief Officer and Clinical Chair Foreword

Welcome to the fifth Annual Report for NHS BaNES CCG.

2017/18 has been a very challenging year for health and care services both locally and nationally.

B&NES, like many parts of the health service, is struggling with growing demand, financial pressures and workforce shortages, which are making it more and more challenging to meet some of the key national targets.

Whilst historically our financial allowance has been fairly generous compared with many other areas, this year we were required to deliver savings of £11.6m (4.5 per cent of our total allocation) to ensure we did not overspend. Consequently, we have had to make a number of difficult decisions on the availability of some products and services such as over-the-counter medicines and IVF treatment. We have also seen some GP practices and primary care services come under even more pressure than in previous years.

Despite these challenges, you will see we have continued to increase the range of services available in the community such as the Falls Rapid Response Service and the development of an Early Home Visiting Service, which both support the resilience of primary care. We also achieved some significant improvements in health care services such as reducing the number of antibiotic prescriptions across B&NES. We have continued to focus on prevention with the introduction of a health optimisation scheme to encourage people to lose weight and stop smoking prior to planned procedures.

We have also continued to work closely with our partner organisations in B&NES, particularly the Council, as part of our on-going plans to further integrate how we work together. Our goal is to commission health and care services in a way that ensures the care people receive is as seamless as possible. This work supports our contribution to the Bath and North East Somerset, Swindon and Wiltshire Sustainability Partnership (BSW STP), with whom we are developing initiatives to improve heath and care services across that wider geographical footprint. This partnership has meant that we have aligned many of our commissioning polices across the three CCG areas and have worked collaboratively on initiatives such as the National Diabetes Prevention programme and Making Every Contact Count.

As always, we would like to thank everyone at the CCG for their dedication and hard work. The CCG has such a talented group of staff that care deeply about health and care services in this local area and strive every day to make services the best they can be.

We hope you enjoy reading this Annual Report and finding out more about what has been happening across Bath and North East Somerset in the past year.

**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 registered with a B&NES GP.

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 B&NES. This is our fifth 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, monitoring and quality assuring contracts, we work with providers to review and develop plans for high quality services and to respond to seasonal pressures on hospital services.

We also work collaboratively with our neighbouring CCGs, B&NES Council and other key stakeholders. During 2017/18, we made progress on plans to further join up the health and social care commissioning functions of the CCG and Council and develop a joint governance framework.

Throughout 2017/18 we worked closely with our colleagues at Swindon and Wiltshire CCGs as our joint Sustainability and Transformation Partnership continued to progress, including the creation of a project team based at BaNES CCG headquarters.

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 187,751 residents in B&NES. There is a significantly higher proportion of residents aged 20-24 years than nationally at 11 per cent compared with 6 per cent, which can be attributed to the high student population.

Population density varies across areas locally, ranging from 41 people per square kilometre in Bathavon North to more than 14,500 for Oldfield Park North 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 2024 the number of over 75s in the population is projected to increase by 18 per cent (approximately 5,600 people) compared with 2014 and the number of over 90s is projected to increase by 53 per cent, compared with 2014.

These changes have steadily increased demand on NHS and social care services, which is mirrored at a national as well as a local level. Indeed, the pressure of our changing population has already begun to impact on our commissioning decisions. This has resulted in some great innovations that seek to make the best use of the expertise held by community-based healthcare professionals, but it has also led us to have to make some very difficult decisions about rationing non-urgent services.

A few more facts and stats

- By 2024, there will be an 11% increase in the B&NES population, to 200,000 people
- B&NES has a high proportion of young people aged 20-24 including 22,000 students
- There will be a 20% increase in people aged 75+ in B&NES over the next five years
- 8,000 people in B&NES are living with Type 2 diabetes
- 92% of patients rate their experience of GP care as good
- 40% of practices have unfilled vacancies
- We spend £24.6m on prescriptions annually
- Every year there are 435,000 face-to-face appointments with GPs
- In 2017-18 there were 109,000 telephone contacts between GPs and patients

- In 2017-18 there were 7,847 ambulance journeys
- In 2017-18 there were 18,842 inpatient emergency attendances
- In 2017-18 there were 151,843 outpatient attendance
- In 2017-18 there were 9,379 Minor Injury Unit attendances
- In 2017-18 there were 6,296 visits to walk-in centres

## 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 B&NES residents are relatively healthy, there are avoidable differences in the quality of health 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 parts of the area.

## Key issues and risks

Similar to the previous financial year, we remain mindful of the broader social, economic and environmental challenges our local population faces as we perform our role. The effects of a long period of national austerity are felt by our population in all areas of public service. In addition, there are specific risks that the CCG faces when commissioning health and care services, which often mirror the national NHS picture.

Our risk register is presented to the CCG Board at intervals throughout the year, and is also published on our website, for example, alongside February 2018's Board papers: bit.ly/Feb18BoardPapers.

**Demand**

We have continued to experience an intense demand on all health and care services throughout the year. There were particular spikes of pressure on acute health services during autumn 2017 when some major IT changes were introduced at the Royal United Hospital, and again in January when the system felt the full force of the local flu outbreak.

The pressure on primary care services has also continued to increase exponentially throughout the year, with the growing emphasis on the need to provide more services in the community and away from hospital. Plans to adapt the way primary care copes with the increase in demand are progressing well, indeed, two of Bath's largest practices went ahead with a merger this year to become 'Heart of Bath'. This partnership provides opportunities for improved access to GPs, nurses and other services and means the practices can save money by sharing back-office functions.

**Performance**

As in previous years, we have not achieved certain NHS constitutional standards such as A&E waiting times and referral-to-treatment times. Most significantly, the A&E 4-hour standard was

not maintained at all times during the winter months, despite comprehensive preparations by all of our partners in the health and care system.

We are fortunate to have regular, open communication with our providers and stakeholders in B&NES, which allows us to attempt to resolve the issues that impact on the whole health system's ability to deliver these constitutional standards.

**Quality, safety and experience of care**

We are committed to ensuring that the quality of health and care services is constantly improving and that service users are safe. However, we know that if we are not meeting NHS constitutional standards, then the quality and experience of patient care may be at risk of being compromised.

Our goal is that patients', service users and their families and carers' all feel able to feed back their experience of care and report that standards of care in B&NES are good, that they would recommend them to their own family and friends, and that services are delivered safely and effectively.

**Finance**

During 2017/18, such was the extent of the financial challenge we faced, the CCG developed a whole new way of working, bringing the entire CCG workforce together to focus on achieving financial balance. You can read more about our Quality, Innovation, Productivity and Prevention (QIPP) programme on page 21.

This programme is delivering bold, innovative pilots that seek to make the best use of our limited resources, while generating savings (see the Falls Rapid Response Service on page 22). Our QIPP schemes also led us to consider restricting access to services entirely in order to make savings and in late 2017/early 2018 we consulted with the public on proposals to stop funding for sterilisation, vasectomy and IVF treatment (under certain criteria). You can read more about this consultation and the results on page 16.

Since our NHS England-agreed Financial Recovery Plan was put in place and the CCG adopted this new way of working, we have achieved savings and efficiencies of a magnitude never seen before. Yet the challenge remains, and while we achieved a balanced financial position at the end of 2017/18, we have an unidentified savings gap of circa £2m going into 2018/19. This position may continue to occur as demand and costs continue to rise beyond our allocated budget.

One of the ways we are hoping to future proof our financial position is with a determined focus on joining up health and care services locally by integrating the CCG with B&NES Council's People and Communities Directorate. You can read more about this on page 10/11.

## Joining up and collaborating across our health and care system

We need to break down the barriers between different organisations and better coordinate services, especially for people with complex conditions who receive care and treatment from

several different organisations. Therefore, in common with many other parts of the country, we are looking at how we can work with partner organisations to bring all our resources together to provide the best quality care and health outcomes for our local population and jointly support prevention initiatives. This is a model of care that is known as an integrated health system and locally there are three variations of this model at different stages of development:

**B&NES, Swindon and Wiltshire Sustainability and Transformation Partnership (STP)**

Together with health and care organisations across B&NES, Swindon and Wiltshire we are working to develop and oversee delivery of shared plans to drive up the quality of services across our combined area, improve health outcomes and ensure our services are cost-effective and sustainable. Our CCG is an active member of the STP and our Accountable Officer leads the proactive and preventative care work stream. During 2017/18, there has been collaboration across B&NES, Swindon and Wiltshire to:

- procure a system-wide integrated urgent care service to include the Out of Hours service, NHS111 and clinical hub
- develop system-wide estates and digital plans
- develop and implement a system-wide Financial Recovery Plan
- work together to develop a maternity transformation plan in line with national guidance
- work towards making all NHS sites smoke-free by early 2019 as part of a shared focus on prevention initiatives.

In 2018/19 our STP's priorities are to transform the care and wellbeing of our older population and transform mental health services. The CCG is collaborating with STP organisations to explore further opportunities to commission services together (rather than separately by each CCG) and develop new integrated models of care that are high quality and offer efficiency gains.

More information can be found on the B&NES, Swindon and Wiltshire STP website.

**Integrated Care Alliance**

In Summer 2017, senior leaders from local health and care organisations in B&NES met together and agreed to work closer together to take collective responsibility for managing the local health and care budget and making quality improvements to local services. The CCG has played a pivotal role in bringing this alliance together as we are passionate about the contribution we can make to system leadership. Alongside the CCG, members of the new Alliance Board include representatives from Avon and Wiltshire Mental Health Partnership NHS Trust, B&NES Council, the Royal United Hospitals NHS Trust, Virgin Care and Healthwatch as well as representatives from primary care and the voluntary sector. The Alliance is now in the process of developing shared priorities for 2018/19.

**Integrating health and care**

During 2017/18, the CCG and the Council began exploring options for working together more closely to improve the health and wellbeing of local people. In November 2017, plans were ratified by the CCG Board and Council Cabinet to combine the funding and expertise from both organisations to make the local health and care system work more efficiently.

To reduce the pressure on GPs, hospitals and care homes, there is a pressing need to provide better support in people's homes and communities to help them stay healthy, happy and independent for longer. Working together will reduce duplication so we can use more of our combined resources to support the growing number of people in B&NES who are living with multiple, complex conditions.

Joining up the local budgets for health and social care will make it easier for health and care professionals to work together to minimise the amount of time that people have to spend in hospital or other care settings. Those who currently rely on local health and care services won't see any immediate changes to their care but in the longer term they will receive support that is more tailored to their individual needs.

During 2017/18, the CCG held workshops with Councillors, senior Council officers and staff from across both organisations to discuss the opportunities and challenges of working together more closely. In 2018/19, the feedback from these sessions will be used to develop the governance, systems and structures required to realise the benefits of integrated health and care along with the shared values and culture that will provide the foundation for success.

## Working together on prevention priorities

As mentioned above, we already work closely in partnership with our colleagues at B&NES Council, including the public health team which helps support our goal to tackle health inequalities and promote healthy lifestyles.

We work particularly closely with these colleagues on campaigns such as ensuring those who are eligible take up their free flu vaccination, Stoptober (smoking cessation), Dry January (alcohol awareness), awareness of antibiotic resistance and the importance of maintaining a healthy lifestyle. Results from the B&NES-wide 'Voicebox' survey in 2017 show for example that 79 per cent of the population are aware of the flu campaign, which indicates strong local recognition of our efforts.

The B&NES public health team have also been instrumental this year in helping the CCG develop and deliver plans for a period of 'health optimisation' before non-urgent surgery. The team provided their expertise when we went out to consult the public on these plans, and also advised on how long people should be asked to try to stop smoking and/or lose weight before being referred for surgery. You can read more about this project on page 16.

### Our stakeholders

The CCG Ipsos Mori 360 stakeholder survey helps us to monitor our relationships with our stakeholders, from GP members to our local Healthwatch. In 2017 we scored above average in a couple of key areas. For example, 77 per cent of survey respondents rated their working relationship with the CCG as good, 89 per cent said they felt able to raise concerns about the quality of services we commission, and 84% believe the CCG has effectively communicated its plans. Almost all respondents (98 per cent) said they felt they know about the CCG's plans and priorities.

However, we have a number of areas to address. Just over half of respondents said that our clinical leadership is delivering continued quality improvements and just under half believe that the CCG takes on board suggestions for improvement.

**Our GP members**

The CCG is clinically-led and our GP members continue to play a critical role in bringing their medical expertise to inform and help shape commissioning decisions. During 2017/18 local GPs have contributed to all of our QIPP schemes and other service improvements. In March 2018 we appointed a group of primary care integrators who will work with the CCG, practices and Virgin Care to develop community-based integration models.

Results from the Ipsos Mori survey highlighted some dissatisfaction amongst GPs with the CCG with only 48 per cent reporting that they were satisfied with how we engage with them. This prompted us to conduct a further survey among our primary care partners to seek more detailed feedback.

This feedback and the Ipsos Mori survey results have informed an updated communications strategy for primary care. Actions we have already undertaken include increasing the frequency of our GP newsletter to weekly and renaming it the 'Primary Care Newsletter' to make it clear it is aimed at all staff in the primary care environment. We have also improved access to the members' area of the CCG website by removing the need to enter a password, and we have updated the format of our Primary Care Forum meetings so they are more relevant for the wider practice team and allow more time for group discussion and feedback.

## 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**

The outcomes of our staff survey in 2017 were very positive. There was an impressive 75 per cent response rate, demonstrating a highly engaged workforce. Of those who responded, 89 per cent said they felt part of a team, 72 per cent felt they were treated fairly and their contribution was recognised and 85 per cent of staff felt they had the skills needed to perform their role.

We have created an action plan to address the areas of the survey where we thought further improvements could be made, including making improvements to our intranet and monthly staff briefings to encourage more effective working. Each team at the CCG is being supported to create a 'team space' on the intranet to showcase their work, answer frequently asked questions and help colleagues understand their roles better. There has also been an effort to streamline meetings, organise for all staff to have access to all calendars and there is now a weekly update following Executive Team meetings.

We have also introduced an 'employee of the month' award at staff briefings. This award gains no particular prize, but the nominations are put forward by members of the Executive Team

and recognises those individuals or teams who have gone the extra mile during a project or event.

### Wellbeing Group

The CCG takes its staff wellbeing very seriously and after the results of a previous survey indicated that wellbeing could be improved, the CCG Wellbeing Group was established. It meets every quarter to discuss ways to improve staff wellbeing as well as the office environment. Results from the latest staff survey show that a third (33 per cent) of staff have come to work despite not feeling well enough to perform their duties.

In summer 2017, the Wellbeing Group enrolled CCG staff for the second year running into the Global Corporate Challenge and, alongside 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. Further to this, the Wellbeing Group is subsidising an ongoing programme of yoga classes held at the CCG, and there is also a running group that meets once per week, to help people fit exercise into their regular schedule.

The Wellbeing Group also introduced a programme of mental health training for staff and encouraged employees to have the flu jab to help protect them from getting flu and to avoid its spread to colleagues and patients. During winter 2017, the uptake for BaNES CCG staff was 80 per cent, which exceeds the national target of 75 per cent uptake expected at NHS organisations.

### Training and development

The most recent staff survey revealed that a third of staff felt they had been unwell as a result of work-related stress, and so the in-house training the CCG has offered has been tailored to try and improve this. Two courses in particular, run by our Commissioning Support Unit, were offered as a direct result of staff feedback about struggles with capacity and resource, and feeling like they needed 'less demands to deliver within such tight timescales'. These were about improving personal effectiveness and dealing with stress and remaining resilient. Both courses were well attended and received by participants.

## Engaging people and communities

### Patient and public involvement

We are committed to putting patients, people who use services, carers and the wider public, at the centre of everything we do. We believe that patient and public participation helps us to understand people's needs and ensure that health and care services are better designed to meet these needs.

This section is divided into three sub-sections:

1. **Our structured approach to patient and public involvement**
2. **Specific engagement activities we carried out in 2017-18**

## 3. Our score for the patient and community engagement indicator (as part of the Improvement and Assessment Framework) 2017-18

### 1. Our structured approach to patient and public involvement

- Our **Your Health, Your Voice** group meets every two months and provides' an opportunity for the public to feedback on our plans to improve local health services. The group is chaired by our Lay Member for Patient and Public Involvement and acts as a critical friend to the CCG, discussing proposed service changes with commissioners from planning to delivery.

Members are also encouraged to inform and support the CCG's engagement with the wider public, by advising on different approaches and groups who we should consult with, and sharing information and surveys with any other local/community groups they are involved with.

This year, members have been asked to share their views on a range of topics including:

- How the CCG should consult on, and present, its Getting Fit for Surgery scheme;
- What changes need to be considered, and which groups need to be consulted with, as part of the current review of community mental health services;
- How access to primary care can be improved;
- How we can encourage people to give feedback on services and patient experience;
- What they thought of the CCG's proposals to restrict access to fertility and sterilisation services (in order to make necessary financial savings); and
- How changes to integrated urgent care services should be communicated with the public.

The findings of this group are formally reported to the public Board for review and discussion. Minutes from the meetings are available on the CCG's website.

We are keen to recruit new members to the group in 2018 and will be targeting specific areas and communities who we need representation from.

- We also coordinate a group of **Community Champions**, jointly with the Council. Community Champions share their experiences and ideas for developing new services and supported our community services review, which resulted in the appointment of Virgin Care as the primary provider from April 2017.

The Community Champions continue to be closely involved in the transformation of community health and care services, attending meetings with commissioners and Virgin Care across a number of different projects. We are currently recruiting more Community Champions to co-produce models for how community mental health services could be delivered in the future (see section on the Mental Health Review for more information about this project).

- Members of the public are **welcome to attend our Board Meetings in Public** and have the opportunity to submit questions beforehand. We regularly invite patients to share their personal experiences of health and care at the beginning of these meetings.

- We are setting up a **patient and public involvement e-bulletin** in 2018, which will be shared quarterly with Your Health, Your Voice members, Community Champions and other people who would like to receive opportunities to share their views and be involved in the work of the CCG.

## 2. Specific engagement activities we carried out in 2017-18

### Review of community mental health services (jointly led by the CCG and Council) (Phase 1)

- **Type of activity:** local public consultation (May – August 2017)
- **Who did we ask and what?** We asked people who use services, the people who care for them, the people who provide services, and the general public, to tell us what they think of community mental health services and how they think they could be improved. To ensure we heard the views of young people, we held a focus group at Off the Record and promoted the survey via universities and Bath Area Play Project.
- **Impact and next steps?** We had more than sixty face-to-face meetings and focus groups and received over 100 responses to tailored surveys from people who use services, carers, service providers and primary care professionals.

  The views, experiences and ideas people shared with us during this phase of the review have been developed into a set of themes (during phase 2), which will inform the development of a new model for delivering community mental health services.

  Phase 3 of the review will focus on everything we have learnt so far and be broken down into six areas of work. From April-October 2018, commissioners, service providers and Community Champions (public representatives – see section above) will work together to co-produce what these new service models could look like, including further public consultation to test these models during the summer. Transitions from child to adult mental health services is a key focus, so we will be asking young people aged 16-25 to volunteer as Community Champions on this area of the review.

  You can read our engagement report for Phase 1 of the Review and find out what people have told us so far on the CCG's website.

### Improving access to Primary Care

- **Type of activity**: Local public consultation (June – July 2017)
- **Who did we ask and what?** We asked patients and the public to share their views in a survey on the different ways they prefer to book an appointment with their GP. We also asked our Your Health, Your Voice group how they think access to primary care could be improved.
- **Impact and next steps?** We received over 400 responses to the survey. You can find out what is happening next on the CCG website.

This will inform our plans and we will be engaging further with a range of groups to find out how we can improve access to primary care and patient experience.

**NHS Funded Patient Transport Survey**

- **Type of activity**: regional public consultation (October – November 2017)
- **Who did we ask and what**? CCGs across the South West asked patients and the public who they think should be eligible for NHS-funded patient transport, to help ensure that NHS-funded non-emergency patient transport is provided in a fair way for all those who need help getting to hospital appointments.
- **Impact and next steps**? We received 219 responses to the survey in B&NES (there were 2157 responses in total across the South West). This feedback will inform the development of the service model and specification over the coming months, with further input from key patient groups who changes may affect.

**'Getting fit for surgery' scheme**

- **Type of activity:** local public consultation (October 2017 – January 2018)
- **Who did we ask and what?** We asked patients, the public and professionals what they thought of our plans to ask people who smoke and have a body mass index (BMI) of 30 or higher to try to stop smoking and/or lose weight before they are referred for surgery. To make sure we heard the views of young people on this proposal, we ran a focus group with a group of sixth formers and promoted the survey via universities, Bath College, Off the Record and Bath Area Play Project.
- **Impact and next steps?** We received over 300 responses to the consultation (including 149 face-to-face conversations). Find out what people told us on the CCG website.

  People's views informed the final design of the scheme (including timescales) and feedback on how stop smoking and weight management services could be improved has been shared with Virgin Care and B&NES Council's Public Health team to inform the review of lifestyle services that is currently taking place.

**Proposal to restrict access to fertility and sterilisation services**

- **Type of activity**: local public consultation (November 2017 – January 2018)
- **Who did we ask and what?** We asked patients, the public and professionals to share their views on our proposals to restrict access to fertility treatment and stop funding vasectomies and sterilisations in all but exceptional circumstances. To make sure we heard the views of young people who could be affected by the proposal in the future, we ran a focus group with a group of sixth formers and promoted the survey via universities, Bath College, Off the Record and Bath Area Play Project.
- **Impact and next steps?** We received over 1100 responses to the consultation (including 138 face-to-face conversations during 'street consultations', focus groups and 1:1 discussions). Please note: we have also shared information about our financial situation and recovery plans, and consulted with the public, via our website and social

media channels, at Board in Public meetings and our AGM, and via the local media. Find out what people told us on the CCG website.

The final decision, on the basis of public feedback and the likelihood of incurring greater costs (associated with unplanned pregnancies than the costs incurred by vasectomy), was to continue to fund vasectomies. Similarly, women will be able to access NHS-funded sterilisations if they have first explored alternative, less invasive forms of contraception. With regard to fertility services, the Board balanced public feedback with clinical evidence on IVF success rates and the CCG's financial decision. You can read more detail about this in our news story.

**Information, updates and opportunities to get involved with engagement activities are all shared on the 'Get Involved' section of our website.**

### 3. Our score for the patient and community engagement indicator (IAF) 2017-18

CCGs are now assessed by NHS England on our patient and public involvement every year. For 2017-18, the CCG received a Green RAG (red/amber/green) rating and a score of 12 (out of a possible 15). Here are the ratings we received for specific areas:

| Domain | What this covers | Our rating |
|---|---|---|
| A (Governance) | • Involve the public in governance<br>• Implement assurance and improvement systems<br>• Hold providers to account | Outstanding |
| B (Annual Reporting) | • Demonstrate public involvement in Annual Reports | Good |
| C (Practice) | • Explain public involvement in commissioning plans<br>• Promote and publicise public involvement<br>• Assess, plan and take action to involve<br>• Provide support for effective engagement | Good |
| D (Feedback and evaluation) | • Feedback and evaluate | Outstanding |
| E (Equalities and health inequalities) | • Advance equality and reduce health inequality | Good |

We received the following comments:

- The involvement page was easy to navigate around. It gave good evidence of the different engagement opportunities and current work.

- It was evident from the review the CCG were committed to public involvement, with visibility in commissioning intentions and communications and engagement and quality strategies.

- Some consideration may want to be given to offering some different approaches and formats of communication when involving patients and the public.

And two areas for improvement were highlighted:

1. Annual reports do not follow national guidance, and so are not as accessible and engaging as they should be.

**Our action plan:**

**In this section of this year's annual report, we have focused more on the impact that patient and public involvement has had, rather than just activity and process.**

**We are producing an additional 'Impact of public involvement – you said, we did' mini report, which will be short and visually appealing.**

2. No clear instructions for the public about how to get information in different formats (e.g. Easy Read, Braille, community languages).

**Our action plan:**

**We are now explaining how people can access alternative formats across our website and in all of our reports and resources.**

**We are going to add to our web page on the Accessible Information Standard to reference more tools and support that are available for people.**

**We are making an effort to produce more visual information e.g. infographics.**

In 2018-19, we are planning to further develop and improve our approach to patient and public involvement, ensuring that people in B&NES shape and influence our commissioning activities. This will include restructuring the 'Get Involved' section of our website and growing the network of community groups we engage with.

## Reducing health inequalities

We are committed to engaging with a diverse range of local groups and communities and ensuring their voice, experiences and needs inform different areas of commissioning. During our public consultations on Getting Fit for Surgery and proposals to restrict access to fertility and sterilisation services (please see above) we proactively engaged with groups of people who we have struggled to seek the views of in the past, including: men, people who are homeless, people who have learning disabilities, young people and those living in rural/remote areas.

We are working with partners across B&NES to continue to reach out to seldom heard and vulnerable groups. Services and schemes that support and engage with those groups include the homeless service run by Bath GPs operating from Julian House – Bath's homeless charity. In addition, our health optimisation pathway supports anyone needing non-urgent surgery who is obese or smokes to adopt a healthier lifestyle before their procedure, thereby improving their outcomes.

## Social media engagement

We use our social media channels to share CCG news, events and projects as well as to post general health information and signpost to services in B&NES. Our strategy of using local 'influencers' to help ensure our messaging is spread throughout the B&NES population continues to work well, borne out by the large reach we achieved during our two major public consultations this year.

### Twitter

- Our followers increased from 1,200 to 1,600 with a relatively even split between members of the public/interested individuals (e.g. media) and other health organisations.
- We post an average of 22 times per week, using material from national campaigns, local initiatives and CCG projects. We also highlight awareness weeks and give information about services that are open during public holidays.
- The stories our followers engaged best with through the year were; when Virgin Care took over community services in B&NES, when we announced the closure of a practice in Bath, and when a B&NES GP stayed overnight at her practice to make sure it could open during storm Emma.

### Facebook

- We increased our page likes from 90 to 160 this year, and while this means we have low organic reach, we have begun regularly incorporating paid advertising into our campaigns and projects which has boosted our following and ensured our messages go further.
- Our most successful organic reach (12,000 accounts) was during one week where we shared information about an outbreak of measles and the importance of having up to date MMR vaccinations. We have also had successful engagement when we post videos. Video content not only takes advantage of Facebook's algorithms and is therefore shown more prominently, but results in us gaining more page likes.

- Our paid posts (‘boosted’ posts and full advertising campaigns ranging from £20 to £100 spent), encouraging people to take part in our consultations, to download the paediatric HANDiApp and to find out which pharmacies are open during public holidays, reached up to 20,000 accounts each time.

# Performance analysis

## A new way of working for 2017/18

Because of the financial challenge facing the CCG during 2017/18, we began a new way of working in order to meet the challenge. To support our Quality, Innovation, Productivity and Prevention (QIPP) programme, we set up five work streams that developed and delivered quality, cost-saving initiatives.

The CCG's working focus was directed almost entirely to the 'big ticket' items in our QIPP during the course of the year. Each programme had a project team comprising staff from across the organisation, including clinical, analytical, financial, quality, administration and communications and public involvement specialists.

As well as enabling the CCG to achieve its goal of financial balance, working in this way has also empowered senior members of staff to demonstrate their accountability, as well as harnessing the benefits of collaborative working.

Below are the programmes from 2017/18 and some examples of the specific QIPP initiatives. You can read more about some of these initiatives in the subsequent pages.

| **QIPP programme** | **Initiatives to generate savings** |
|---|---|
| Medicines optimisation | ● Stopping most prescriptions for gluten-free and over-the-counter products<br>● Replacing branded medicines with generic versions<br>● Using IT programmes to remind prescribers of best practice (OptimiseRX, Blueteq) |
| Urgent care | ● A dedicated frailty nurse<br>● The Falls Rapid Response Service<br>● Urgent Connect service linking GPs directly with consultants<br>● Early Home Visiting service |
| Demand management | ● Restricting access to non-urgent services<br>● Encouraging people to get fit before surgery |
| Continuing healthcare (CHC) and funded nursing care (FNC) | ● Improve the timeliness and quality of assessments for CHC and FNC<br>● Develop efficient and responsive administrative and payment processes |
| Finance and business | ● Ensure payments made to all providers are correct<br>● Validate all activity undertaken by providers |

## QIPP initiatives, projects and cost saving

One of the initiatives that has emerged from our urgent care QIPP work and has generated interest from the healthcare sector as well as the media is the Falls Rapid Response service. Health and care services in B&NES have come together to pilot the service for people over the age of 65 years who fall over at home. The falls team, which includes a specialist paramedic and an occupational therapist, can respond to up to four B&NES patients per day if they have contacted the emergency services for assistance after a fall. The team helps the person get comfortable, carries out a home-based falls risk assessment and recommends any necessary interventions that could help prevent future falls.

In its first year of service, the falls pilot visited over 650 people who had fallen at home, and over 550 of those individuals were able to remain at home after the team's visit. This indicates just how many unnecessary hospital admissions may have been avoided through the intervention of the team. Among those who were transferred to hospital, the most common reason was for further clinical assessment, as opposed to a lack of available community based support.

Another strand of the urgent care QIPP programme resulted in the launch of the Early Home Visiting Service. People living in B&NES who are unwell and cannot get to their GP surgery to be seen can now call the practice first thing in the morning to request an early home visit (i.e. ideally before 10am). The goal for this early visit is to enable patients who might need to go to hospital for a check to do so and return home again on the same day. Historically, home visits are done during late morning after a GP's morning session, which means patients may not arrive into hospital for any necessary checks until the middle of the day. This often results in patients staying overnight unnecessarily.

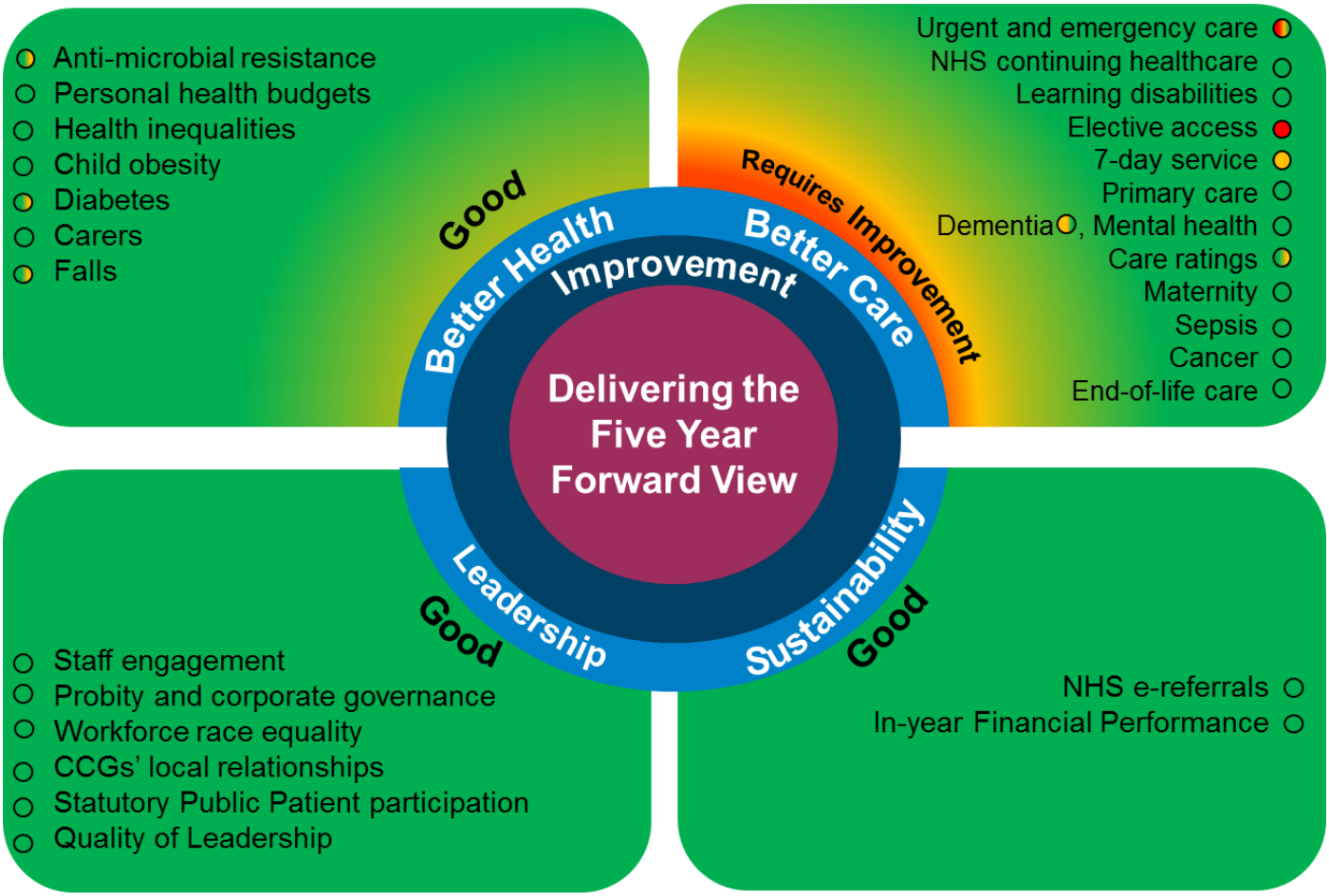
Since the Early Home Visiting Service began in April 2017, our GP members have consistently reported positive effects on their own time management. Having a dedicated staff member to carry out early morning visits has freed up their time to dedicate to those patients who can attend the practice. The service is being extended in 2018/19 to include afternoons, with the emphasis shifting to improving access and avoiding unnecessary admissions to hospital late in the day.

A large-scale public consultation on the future of three non-urgent services also emerged from the demand management QIPP programme. We asked the public and our stakeholders to give their views on proposals to stop funding vasectomies, female sterilisations and restrict access to IVF treatment according to female age, male age, BMI status and duration of trying to conceive. You can read more about this consultation on page 16.

## How we measure our performance

The CCG's annual assessment against national targets gives a rating against the CCG improvement and assessment framework (IAF). This framework aligns key objectives and priorities as part of our aim to deliver the Five Year Forward View.  The CCG has self-

assessed its rating as shown in the table below, and this has been supported by the regional NHS England moderation process so far:




In terms of the 'Better Care' domain, whilst our overall quality of care within the CCG is rated good, NHSE has decided that commissioners facing providers with serious repeat national target failings are automatically downgraded. Therefore, due to the referral-to-treatment and A&E waiting time target performance at RUH, this element has been rated amber.

The tables below set out the CCG's specific performance against the indicators in the Better Health and Better Care domains of the IAF.

## Better Health

| IAF Standard | Target (National average) | 2017/18 (or date available) | RAG | | Is BaNES in the top quartile? (Benchmarked at Jan 18) |
|---|---|---|---|---|---|
| | | | Target | National* | |
| Percentage of children aged 10-11 classified as overweight or obese | - (33.7%) | 28.2% (2013/14 to 2015/16) | - | | ☑ |
| Diabetes patients that have achieved all the NICE recommended treatment targets | - (39.7%) | 38.8% (2016-17) | - | | ☐ |
| People with diabetes diagnosed less than a year who attend a structured education course | - (7.3%) | 3.8% (2016-17*) | - | | ☐ |
| Injuries from falls in people aged 65 and over (per 100,000 population) | - (1,961) | 1,905 (17-18 Q1) | - | | ☐ |
| Personal health budgets (number per 100,000 population) | - (31.5) | 21.1 (17-18 Q2) | - | | ☐ |
| Inequality in unplanned hospitalisation for chronic ambulatory care sensitive conditions | - (2,012) | 1,766 (17-18 Q1) | - | | ☐ |
| Antimicrobial resistance: appropriate prescribing of antibiotics in primary care | 1.161 (1.045) | 0.860 (2018 01) | | | ☑ |
| Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care | 10.0% (8.8%) | 11.5% (2018 01) | | | ☐ |
| Quality of life of carers | - (-) | Data unavailable | - | - | ☐ |

*The national RAG rating considers performance against the national average (where available), the CCG's rank nationally, the quartile in which the CCG is placed and what actions are in place to improve performance.

BaNES is demonstrating good performance in the Better Health domain, with top-quartile performance returned for the percentage of children aged 10-11 classified as overweight or obese and for appropriate prescribing of antibiotics in primary care.

While we perform well at only prescribing antibiotics where necessary, the CCG is higher than the national average for delivering the national intention to reduce prescribing of antibiotics in the broad spectrum category. However, the CCG plan focuses on incremental improvement in performance, which has been sustained over the past year and a half, and is expected to continue due to the primary care antimicrobial stewardship activity.

## Better Care

| IAF Standard | Target (National average) | 2017/18 (or date available) | RAG | | Is BaNES in the top quartile? (Benchmarked at Jan 18) |
|---|---|---|---|---|---|
| | | | Target | National* | |
| Provision of high quality care: hospital | -<br>(-) | 58<br>(17-18 Q2) | - | | ☐ |
| Provision of high quality care: primary medical services | -<br>(-) | 68<br>(17-18 Q2) | - | | ☑ |
| Provision of high quality care: adult social care | -<br>(-) | 58<br>(17-18 Q2) | - | | ☐ |
| Cancers diagnosed at early stage (stage 1 or 2) | -<br>(52.4%) | 59.2%<br>(2015) | - | | ☑ |
| People with urgent GP referral having first definitive treatment for cancer within 62 days of referral | 85.0%<br>(82.2%) | 91.1%<br>(17-18 Q3) | | | ☑ |
| One-year survival from all cancers | -<br>(72.3%) | 74.1%<br>(2015) | - | | ☑ |
| Cancer patient experience | -<br>(-) | 8.9<br>(2016) | - | | ☑ |
| Improving Access to Psychological Therapies – recovery rate | 50.0%<br>(50.8%) | 63.2%<br>(2017 12) | | | ☑ |
| Improving Access to Psychological Therapies – access rate | -<br>(4.0%) | 4.3%<br>(17-18 Q3) | - | | ☐ |
| People with first episode of psychosis starting treatment with a NICE-recommended package of care treated within 2 weeks of referral | 50.0%<br>(75.8%) | 100.0%<br>(2018 02) | | | ☑ |
| Children and young people's mental health services transformation (a measure of delivery of mandated transformation) | -<br>(-) | Data unavailable | - | - | ☐ |
| Mental health out of area placements | -<br>(-) | Data unavailable | - | - | ☐ |

| IAF Standard | Target (National average) | 2017/18 (or date available) | RAG | | Is BaNES in the top quartile? (Benchmarked at Jan 18) |
|---|---|---|---|---|---|
| | | | Target | National* | |
| Mental health crisis team provision | -<br>(-) | Data unavailable | - | - | ☐ |
| Reliance on specialist inpatient care for people with a learning disability and/or autism | -<br>(-) | 22<br>(17-18 Q2) | - | | ☑ |
| Proportion of people with a learning disability on the GP register receiving an annual health check (aged 14 plus) | -<br>(48.8%) | 44.9%<br>(2016-17) | - | | ☐ |
| Completeness of the GP learning disability register | -<br>(47.25%) | 45.55%<br>(2016-17) | - | | ☐ |
| Maternal smoking at delivery | -<br>(11.0%) | 7.8%<br>(17-18 Q3) | - | | ☐ |
| Neonatal mortality and stillbirths | -<br>(-) | 6.06<br>(2015) | - | | ☐ |
| Women's experience of maternity services | -<br>(-) | 87.0<br>(2015) | - | | ☑ |
| Choices in maternity services | -<br>(65.4) | 72.4<br>(2015) | - | | ☑ |
| Estimated diagnosis rate for people with dementia<br>(diagnoses as % of prevalence) | 66.7%<br>(68.7%) | 61.9%<br>(2018 02) | | | ☐ |
| Dementia care planning and post-diagnostic support (GP annual reviews) | -<br>(-) | 82.5%<br>(2016-17) | - | | ☑ |
| Emergency admissions for urgent care sensitive conditions (per 100,00 registered patients) | -<br>(2,353) | 1,996<br>(17-18 Q1) | - | | ☐ |
| Percentage of patients admitted, transferred or discharged from A&E within 4 hours. (Provider data attributed to CCGs) | 95.0%<br>(85.1%) | 76.6%<br>(2018 03) | | | ☐ |
| Delayed transfers of care attributable to the NHS per 100,000 population | -<br>(11.8) | 12.1<br>(2017 11) | - | | ☐ |

| IAF Standard | Target (National average) | 2017/18 (or date available) | RAG | | Is BaNES in the top quartile? (Benchmarked at Jan 18) |
|---|---|---|---|---|---|
| | | | Target | National* | |
| Population use of hospital beds following emergency admission (per 1000 registered population) | - (502.1) | 454.1 (17-18 Q1) | - | | ☑ |
| Percentage of deaths with three or more emergency admissions in the last three months of life | - (-) | Data unavailable | - | - | ☐ |
| Patient experience of GP services | - (84.8%) | 92.5% (2017) | - | | ☑ |
| Primary care access (% of practices offering extended access weekend and evening - all 7 days) | - (51.6%) | 0.0% (2017 10) | - | | ☐ |
| Primary care workforce (Gps and Nurses FTE per 1000 patients in CCG) | - (1.02) | 1.03 (2017 03) | - | | ☐ |
| Patients waiting 18 weeks or less from referral to hospital treatment | 92.0% (89.5%) | 88.4% (2018 02) | | | ☐ |
| Achievement of clinical standards in the delivery of 7 day services | - (-) | Data unavailable | - | - | ☐ |
| Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting | - (23.7%) | 0.0% (17-18 Q4) | - | | ☑ |
| Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG | - (-) | Data unavailable | - | - | ☐ |

*The national RAG rating considers performance against the national average (where available), the CCG's rank nationally, the quartile in which the CCG is placed and what actions are in place to improve performance.

BaNES' performance in the Better Care domain is generally very good, with performance in the top quartile for 14 of 22 indicators for which benchmarking data is available. In addition, the CCG is ranked top in its peer group of demographically similar CCGs for eight measures.

Due to pressure across the health and social care system that has escalated over winter, BaNES' performance against the constitution standards for patients attending A&E being admitted, transferred or discharged within 4 hours and for patients waiting 18 weeks or less from referral to hospital treatment has continued to be below expected levels. BaNES is not alone in facing challenging performance in these areas as the pressure is felt across the country. The CCG continues to work with providers to manage performance in these areas

through forums such as the A&E Delivery Board and the RTT Steering Group. The CCG also works with providers to ensure that patient safety is not compromised during times of increased pressure in A&E and that waiting lists are managed in a way that maximises patient safety and clinical effectiveness.

Another challenging area is that the CCG has identified and diagnosed fewer older adults with dementia than is expected nationally. A change in the national calculation of the number of older adults expected to have dementia has made performance against the diagnosis indicator deteriorate in 2017/18. The expected level of dementia in the population is a subjective area and local intelligence suggests that levels in BaNES are lower than the national calculation indicates. Despite this, the CCG is committed to work towards the national target and is taking steps to ensure that opportunities to diagnose patients are not missed, which is supported by the dementia action plan.

## Compliments, concerns and complaints

We value and act on all feedback received and view compliments, concerns and complaints as a rich source of information.

Responses to concerns and complaints are administered in line with the Local Authority Social Services and National Health Service (England) Complaints 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 2017/18, the CCG received a total of four complaints and three compliments. Most individuals choose to provide feedback directly to the provider of their care if they are either satisfied or unhappy. This explains the low number received by the CCG. The CCG monitors all feedback received directly by providers in contract monitoring meetings to identify themes and trends.

There have been 87 patient advice and liaison service (PALS) contacts received directly by the CCG. The following are examples of actions implemented as a result of issues raised:

- Monitoring of the complaints policy/process relating to our provider of non-urgent patient transport services
- Escalation of concerns raised regarding outpatient appointment contacts
- Creation of a clinical policy to assist in the assessment of patients for suitability of continuous glucose monitoring equipment.

We work proactively with providers 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.

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

## Progress against national priorities

### Dementia

The method for calculating the dementia diagnosis rate changed in April 2017 and has resulted in a 3 percent reduction in diagnoses in B&NES to 59 per cent, meaning we are not meeting the required diagnosis rate of 66.7 per cent. However, diagnoses have increased over the past 12 months and had reached 61 per cent in January 2018.

The B&NES Dementia Action Plan is still operating successfully in order to meet the Prime Minister's Challenge on Dementia 2020. The plan offers individuals access to a dementia support worker, an annual GP assessment and a menu of support options including singing for the brain, access to the memory cafe and information on prescription.

### Long-term conditions

Long-term conditions put significant pressure on health and care services, with 10 per cent of the NHS budget spent on diabetes care alone.

In 2017/18 we introduced a dedicated wellbeing service for people with long-term conditions, to make it easier for these individuals to access Improving Access to Psychological Therapies (IAPT) support.

### Mental Health

Additional funding was made available in 2017/18 to provide additional staffing for mental health crisis and liaison services to meet the needs of people of all ages. We have also achieved the constitutional standard for early intervention in psychosis and 53 per cent of our patients receive NICE-concordant care within two weeks.

### End of Life

End of life care is a priority for us because the quality of care provided depends on so many factors within the wider health and social care system including acute care, community services and palliative care. We also know there are groups of patients who do not receive the best quality care because of their specific circumstances, such as those with frailty, dementia and learning disabilities. In contrast, the standard of end of life care for children and young patients in B&NES is excellent.

One whole strand of our 2018/19 QIPP programme has been dedicated to frailty and end of life care. This includes a dedicated community frailty nurse, plans to develop a 'GP with extended responsibility' for frailty and additional capacity from our local hospice team to provide 'hospice at home' care.

### Diabetes

The CCG was successful in its bid for part of the Diabetes Transformation Fund, which we submitted in partnership with the Royal United Hospital with support from our STP. Our bid focused on reducing the variation in treatment targets and improving the uptake of structured education.

Our vision for this structured education is to maintain links with the lifestyle services run by our community health provider Virgin Care, as well as to introduce the accredited X-PERT Diabetes programme. Furthermore, The Healthier You: NHS Diabetes Prevention Programme (NHS DPP), which identifies those at high risk and refers them onto a behaviour change programme already has a participation rate above 90 per cent in B&NES.

We have been able to achieve our treatment targets this year by standardising the organisation and delivery of diabetes management at GP practice level, including targeted interventions for under 70's, practice nurse and healthcare professional support, and ensuring robust evaluation of all initiatives. In addition, 34 multidisciplinary team 'virtual clinics' have been held this year that have helped 72 per cent of patients move in their target direction with relation to their blood sugar levels.

**Cancer**

The CCG has continued to support and promote public health messages about behaviours and lifestyles that reduce the risk of developing cancer. All of our STP Trusts also agreed to prioritise going completely smoke free in 2018/19. Furthermore, we consulted with the public about introducing a period of 'getting fit' before routine surgery, to support smokers to quit before their procedure to improve their outcomes, and we received positive feedback about the proposals, which are being introduced in 2018/19.

We implemented the NICE two-week wait referral forms for GPs and have worked alongside our STP partners to introduce an electronically bookable appointment system for two-week wait clinics. Our region's cancer alliance was also successful in a bid for transformation monies that will support a streamlined lung cancer pathway and improve quick and early diagnosis of colorectal cancers.

B&NES has a good history of delivering the 62-day cancer standard - from urgent referral from a screening programme to first treatment - with 88 per cent of patients meeting this target through 2017.

**Maternity care**

An STP-wide Maternity System was created in April 2017 in line with national recommendations. This has led to a Maternity Services Forum being established, which will lead our area's Maternity Transformation Plan and implementation of the Better Births plan across our STP. These plans will require a service redesign in order to deliver the improvements required, and work has commenced on this with support from NHS England. Stakeholder events have already taken place to inform and evaluate options before any general consultation with the public, and the case for change will be finalised in the year to come.

**Urgent Care**

Throughout 2017/18 the local system has failed to meet the A&E waiting time target (95 per cent of attendees to be seen within four hours). Across England there has been extremely high demand and this is putting local health and care services under significant pressure.

Some additional national funding was made available during December to support systems. Locally we used this funding to put in place a number of extra initiatives to cope with demand including the provision of additional patient transport capacity and the provision of three additional reablement 'step-down' flats with the support of Curo. In January some non-urgent hospital appointments and operations were postponed in line with national guidance to help hospitals deal with the sustained pressure.

Early in 2018 the CCG, RUH and community providers across B&NES and Wiltshire implemented a Four Hour Recovery Plan. The plan consisted of actions for both the RUH and community providers with a significant focus on reducing the numbers of delayed discharges and patients who have been in hospital for more than 21 days.

Despite the pressures during 2017/18, the local health system has come together to seek to maintain high quality services for patients. This commitment was demonstrated during Storm Emma in March 2018 when there was a coordinated emergency response by public services alongside support from the voluntary sector and members of the public to minimise disruption for patients.

## Our CCG priorities

### Children and young people

We extended a demand management service, set up by the RUH to support GPs treating ill children, to allow GPs to speak to an experienced paediatrician in real time whilst their patient is in their consultation room. The service can also send emails detailing symptoms - including photographs - to a dedicated email address and make joint clinical decisions about whether a child can be home treated or needs to be seen in the hospital.

This service is supported by the digital paediatric HANDI App, which is available for free via iTunes and Google Play, and aimed at both community health professionals and anyone caring for young children. It offers free support and expert advice about how to manage common childhood ailments.

The CCG has worked with B&NES Council's Children's Services team to implement the SEND (Special Educational Needs and Disability) reforms and has further developed the local health offer for children and young people who are eligible for Education Health Care plans.

There have also been a number of notable achievements with Child and Adolescent Mental Health Services (CAMHS)

- The new children and young people's community Eating Disorder Service (TEDS) was launched across the STP in April 2017.

- Self-referral to CAMHS is now established in B&NES and online referrals are also available.

- A specialist mental health service for children and young people was recommissioned across the STP in 2017 and a new service delivery model will begin in April 2018.

- Acute Mental Health Liaison CAMHS practitioners are now based at the RUH to offer mental health assessments and support for children and young people attending ED or staying on the children's ward.

**Community Services**

We are committed to investing in and expanding our community services so that more people can be cared for and treated at or close to home rather than in a hospital setting which can be costly.

Following a two year review of community services (*your care, your way*), Virgin Care was appointed as prime provider of over 70 different services from 1 April 2017. The CCG and Council are working with Virgin Care to make sure our future model for community services addresses the priorities that were proposed by people as part of *your care, your way*. This includes ensuring we have services that are easier to navigate, they are coordinated around the individual and they are joined-up so people only have to tell their story once.

The CCG and Council hold monthly contract review meetings with Virgin Care to monitor performance and track progress on an ambitious three-year programme of transformation that aims to help people stay independent for as long as possible, supported by a multi-disciplinary team of health and care professionals.

Learn more about our community services review at www.yourcareyourway.org

**Primary care**

We have 26 GP practices in our area that are all rated by the Care Quality Commission as 'good' or 'outstanding' and all our practices perform well in the national GP patient survey. Indeed, locally 95 per cent of patients say they have confidence or trust in their GP and over 92 per cent describing their overall experience as 'good'.

The CCG is currently in the process of taking on more responsibility for commissioning and quality assuring primary medical care from NHS England and will become 'fully delegated' in October 2018. This process offers us increased control of budgets, to protect and invest resources where they can be used most effectively.

Our primary care teams are not immune from the pressures which are being experienced by other health services and in 2017/18 we continued to make plans and provide support to help ensure the longer-term sustainability of our practices. This work, which is in line with national guidance (General Practice Five Year Forward View) includes:

- work with partners at Number 18 Surgery, Bath who announced in January 2018 that the business is no longer financially viable and would need to close by September. In collaboration with NHS England and the Local Medical Committee, we are making sure patients continue to receive high quality care until the practice closes and to also facilitate their transfer to another local, convenient surgery later in the year.

- introduction of improved access to services so that GP surgeries offer evening appointments during the week and morning sessions at the weekend. Two pilot schemes are due to launch by October 2018.

- support with formal practice mergers or informal joint working arrangements across two or more surgeries. These collaborations and working 'at scale' offers practices the opportunity to offer patients a wider range of services, share expertise and pool back-office resources. For example, in 2017/18 we supported St James's Practice and Number 45 with their merger to form the Heart of Bath.
- work with practices on major new build or redevelopment schemes so that our primary care estate and infrastructure is fit for the future. For example we are supporting the team at Hope House Surgery and working closely with B&NES Council and other local partners to improve services for residents in the Somer Valley by developing a new community centre in Radstock. This new build will be home to a purpose-built, modern GP surgery and council services due for completion by 2020.

We are in the process of finalising our Primary Care Strategy for 2018-2020 which will be available to download from our website in summer 2018.

**Learning disabilities**

During 2017/18 we began implementing the Learning Disabilities Mortality Review (LeDeR) Programme, a quality improvement programme that aims to identify lessons learned and good practice to improve services and reduce the premature mortality rate for people with a learning disability. We are working in partnership with Swindon and Wiltshire to deliver the programme across the STP.

We have also been working to develop a new local registered care service, primarily to support people with learning disabilities who have complex needs and behaviours. We hope this will reduce the need for out-of-area placements and will enable a more robust, locally coordinated approach for individuals.

We were successful in a bid to the Department of Health Housing and Technology Capital Fund, to support two projects. The first project has been to develop the use of assistive technology for people with learning disabilities and autism living in B&NES. The second has been to support people buy their own home under a Government-approved shared ownership model known as HOLD (home ownership for people with long term disabilities) working in partnership with Advance Housing. We have supported two people to become home owners and have a further two people due to complete on their property sales soon. We will be supporting a further five people to become home owners in 2018/19. All of the people using the scheme have complex needs and require bespoke housing to enable them to live as independently as possible.

## Improving quality and reducing health inequalities

We use the national NHS definition of quality set out by Lord Darzi in 2008. Care provided by the NHS will be of a high quality if it is safe, effective and leads to a positive patient experience.

Quality care is not achieved by focusing on one or two aspects, high quality care encompasses all three aspects with equal importance being placed on each.

We are passionate about quality assurance and quality improvement and have a team of trained quality improvement leads embedded into every area of BaNES CCG.

In 2017/18, our Quality Improvement and Patient Safety Nurse spearheaded the 'red bag' pilot in B&NES. The initiative sees care home residents who need to visit hospital being accompanied by a distinctive red bag, which contains all relevant medical information as well as their personal belongings. The red bags stay with the patient for the duration of a hospital visit and contain specific admission and discharge checklists for medical staff to fill out. These lists help ensure that every member of the medical team receives exactly the same information, and nothing gets misplaced or miscommunicated on the way in or out of hospital.

This year we have also:

- Reviewed and revised processes for Serious Incidents to improve timeliness, ensure involvement of clinical and non-clinical experts and identify learning for the wider health system.
- Commissioned an external review of our medicines team to ascertain current performance and identify areas where improvements can be made .
- Developed a joint Commissioning for Quality and Innovation (CQUIN) panel with Wiltshire and Swindon CCG.
- Completed audits of our continuing care and funded nursing care packages to identify areas where processes can be improved.
- Aligned safeguarding responsibilities for adults, children and domestic abuse to improve efficiencies, share best practice and avoid duplication.
- Carried out an audit on Diabetes Type 2 across all 26 GP practices with a focus on cardiovascular disease risk management. In particular, patients not prescribed statins, patients who have blood pressure above target and long term insulin analogue prescribing in the cohort. This work is progressing well with good engagement from the practices
- To develop a Safer Care Culture, the CCG is using IT systems such as OptimiseRx, TPP and Ardens to support safer use of medicines. The Medicines Team continue to use newsletters and notifications to the GP practices to identify and put in place safer medicine processes
- Key work has been undertaken to establish a joint commissioning quality framework for care homes by the CCG and Council and this is in the process of being finalised and a joint quality dashboard will be developed.

A joint campaign we ran with B&NES Council public health team and community services provider to raise awareness of the importance of using antibiotics appropriately also won in the Community Engagement category of the 2017 national Antibiotic Guardian awards.

The campaign saw Year 3 B&NES pupils design posters showing how to wash your hands, catch your sneezes and make sure you take antibiotics properly. The posters were displayed in locations in and around B&NES including sports centres, libraries, pharmacies, GP's surgeries

and the Royal United Hospital, and members of the public who saw them were encouraged to upload photos to social media.

## 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 national quality improvement goals and innovation. For this year, our providers have started to implement the national two-year CQUIN programme as set out by NHS England which aims to improve the quality and outcomes for patients including reducing health inequalities, encourage collaboration across difference providers and improve the working lives of NHS staff. Further information on the content of the national CQUIN programme for 2017-19 can be accessed via with NHS England CQUIN website.

The review of the first year of progress will be completed at the end of April 2018 as per the national CQUIN guidance timescales and the results will be available on our website at the beginning of June 2018. In year monitoring of progress has highlighted:

- Regular auditing to monitor the timely identification and treatment of sepsis.
- Promotion of the flu vaccination for frontline clinical staff.
- Collaboration between our acute and mental health providers to improve the services for people with mental health needs who present to A&E.
- The roll-out of Consultant Connect at the RUH which allows GPs to access consultant advice over the telephone prior to referring patients into secondary care.
- Increasing the number of consultant-led 1st outpatient services available on the NHS e-Referral Service.
- Providers focussing on taking action on alcohol consumption and smoking whilst people are accessing their services.
- Improving the quality and monitoring of wound healing progress and treatment in community services.

## Better Care Fund

Our plan for the Better Care Fund reflect the vision and strategic priorities for integrated health and care set out in existing plans including B&NES' Health and Wellbeing Strategy and our two-year community services review, *your care, your way*. This strategy sets out our commitment to maintaining independence and supporting people at all stages of their lives. Indeed, the Better Care Fund is the vehicle for the pooled budget that supports the delivery of that strategy.

Our focus is on reducing non-elective admissions, reducing delayed transfers of care, reducing admissions to permanent care and improving the proportion of older people over 65 years still living at home 91 days after discharge from hospital into reablement.

During 2017/18 we developed our Home First service to cover seven days per week so patients who no longer need hospital care, but might need a bit of extra support, can go home as soon as possible.

Patients are only discharged when the ward team have completed the necessary checks to make sure they are medically-fit. Once at home, the patient is met by a therapist and reablement workers who immediately provide a detailed assessment and organise support for up to six weeks to help the patient regain the skills and confidence to live at home independently – rather than stay in hospital.

Across our health and care partners we have agreed a common aim for Home First - *to minimise your hospital stay and maximise your independence*. Since October 2017 Home First has been supporting up to 25 patients every week, including weekends, to return home and regain their independence.

Also during 2017/18 and in collaboration with the Council we have opened five 'Discharge to Assess' beds, and are working with Care Home Selection to support self- and local authority-funded residents into care homes in a timely way. This has also helped to manage the care home market. The three care homes transitioning to a new model have also worked hard this year to implement their new models. A new approach to assess adult social care support, known as the 'Three Conversations' model is also being piloted by social care workers in B&NES, and was launched in February 2018 in collaboration with Virgin Care. This model brings together staff to share personal experiences, case studies and data to improve services for local people.

## Optimising our use of medicines

Our GPs write four million prescriptions, at a cost of £25 million annually, for people in B&NES. Our medicines management team works closely with practices to make sure these medicines are safe and effective for patients, while providing good value for the NHS. B&NES continues to be one of the most cost effective CCGs in England for its use of medicines.

Indeed, the CCG has had an exceptionally good year for delivering savings in the medicines budget, including over £1.1 million saved in both our primary and secondary care 'high cost' medicines prescribing budgets. These savings have been achieved by implementing IT systems that help ensure clinicians choose the most appropriate medicines at the point of prescribing. We have also worked with prescribers and patients to achieve a high uptake of biosimilar medicines in secondary care, which are less expensive than their branded counterparts.

The CCG's medicines management 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:

- Ongoing collaborative work around the appropriate use of antibiotics. This has resulted in a reduction of antibiotic prescribing – in particular broad spectrum antibiotics.

- Continuing work on the appropriate use of anticoagulation medicine to reduce the number of strokes.
- Engaging with NHS England on their proposals to disinvest in medicines of limited clinical value – especially those medicines available over-the-counter at pharmacies.
- Working with community pharmacists to help identify medicines people may not require on their repeat prescriptions.
- Developing the pharmacy workforce within primary care.

**Pharmacy supporting primary care**

In 2017/18, B&NES GPs were successful in a bid for funds from NHS England to provide four clinical pharmacists who will be working across half (13) of our practices to create a more sustainable workforce model. In addition, the CCG has made a bid to increase the medicines optimisation workforce, working with care homes to help improve clinical outcomes and minimise any inappropriate prescribing in this setting.

## Equality and diversity

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.

To achieve our aim of designing and commissioning services to provide high-quality health care that is fair, accessible to all and meets the needs of our diverse communities, we carry out equality analysis (equality impact assessment) as an integral part of commissioning projects to identify who the CCG should consult with.

We require all providers of healthcare services to comply with the requirements of the Equality Act, Human Rights Act and the NHS Constitution. This includes ensuring that providers are assessed on equalities performance at all stages in procuring a contract and during our quality assurance programme receiving evidence that the organisations are making them accessible and that they meet the needs of the community.

During the commissioning of urgent care and we have made sure the health services we buy are accessible and meet the needs of our local community and we have robustly considered health inequalities as part of our consultations on difficult decisions and health optimisation.

All our staff are required to undertake yearly training on equality and diversity.

We continue to be committed to improving our Equalities Data and Intelligence data and our use of equality analysis data in our commissioning cycle and we plan to build stronger relationships with protected groups and communities to better understand their needs and improve our equality data.

## Health and wellbeing strategy

The CCG's Clinical Chair, Dr Ian Orpen, co-chairs our local Health and Wellbeing Board alongside the B&NES Council Cabinet Member for Adult Social Care and Health, Cllr Vic Pritchard, and has continued to maintain the CCG's position of influence on the Board.

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

In recognition of the wider determinants of health, the membership of the Board has recently been expanded beyond the local health and care community to include wider representation from public services. New board members include representatives from Avon and Somerset Police, Avon Fire and Rescue Service, housing and the higher and further education sectors. There are also new health and social care members, representing acute care, community care, primary care and the voluntary, community and social enterprise sector that are all committed to working together on prevention and health initiatives for the benefit of our local population. During 2017/18 the CCG has demonstrated system leadership by lead on a number of development workshops for Board members in order to build the group's effectiveness and further empower members to help shape local services.

The Board has a key working relationship with B&NES Council's Health & Wellbeing Select Committee and Children & Young People Policy Development & Scrutiny Panel and plans further engagement with them as work streams progress.

Over the past year the Board has put a particular emphasis on mental health. It has endorsed a Mental Health & Wellbeing Charter and recommended that Board members took the charter back to their representative organisations to adopt the principles set out in it. It discussed the Prevention Concordant, which is a shared commitment by a wide range of national organisations, representing an approach to improving people's mental health and reducing the risk of mental illness. The Board has also lent its support to a 'year of mental health', including planning events to raise awareness of mental health issues and tackling the stigma.

## Sustainable Development

**Introduction:**

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

During 2017/18 we have delivered the following:

- Continued awareness-raising of our Sustainable Development Management Plan across the organisation through presentation to staff groups and formal reporting to the Joint Commissioning Committee and Board
- Ongoing review of policies and procedures to ensure sustainability considerations are recognised, including our Records Management, Health and Wellbeing and Flexible Working policies
- Ensuring our procurement protocols include environmental considerations including the use of Cabinet Office mandated standards for larger procurements

- Ensuring oversight of provider engagement with sustainability matters through contractual mechanisms
- Increased use of Skype and conferencing facilities to reduce travel
- Extension of our paperless approach through roll out of laptops and regular action to reduce retained paper records
- Continuing initiatives to improve the working environment and staff wellbeing, including encouragement of physical activity
- Incorporating sustainability targets as a key goal within our Estates Strategy

During 2018/19 our focus will be on the following objectives:

- Delivering the third year of our action plan approved by the Board as part of the Sustainable Development Management Plan, and building on the successes of the previous years, 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
- Exploring opportunities for wider working with partners on sustainability matters through our expansion of joint working with the Council and our engagement with the developing Sustainability and Transformation Partnership Estates forum
- Working with our landlord, NHS Property Services, and other tenants of the St Martin's Hospital site to understand and reduce energy and water usage and extend waste reduction and recycling initiatives

**Carbon Emissions:**

Using the Sustainable Development Unit modelling tool, our estimated carbon footprint for 2017/18 from all our activities including services commissioned by us is 50,893 tonnes of carbon dioxide equivalent emissions (tCO2 e) (2016/17 50,145 tCO2 e). Within this figure, 50,309 tCO2 e are related to healthcare services commissioned by the CCG (2016/17 49,691 tCO2 e) and a further 519 tCO2 e (2016/17 364 tCO2 e) was generated through procurement and contracted out business support services, for example the Commissioning Support Unit, auditors, and payroll. These figures exclude the impact of delegated primary care services which we are in the process of taking on fully from NHS England.

The main reason for the increase in carbon emissions from 2016/17 to 2017/18 is increased spend by the CCG on the commissioning of healthcare. The increase in carbon emissions associated with contracted out business support services is driven by the higher general running and premises cost of the CCG offices.

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 2017/18, the CCG as a corporate body produced 75.33 tCO2 e compared to 89.61 tCO2 e in 2016/17 – a reduction of 14.28tCo2 e

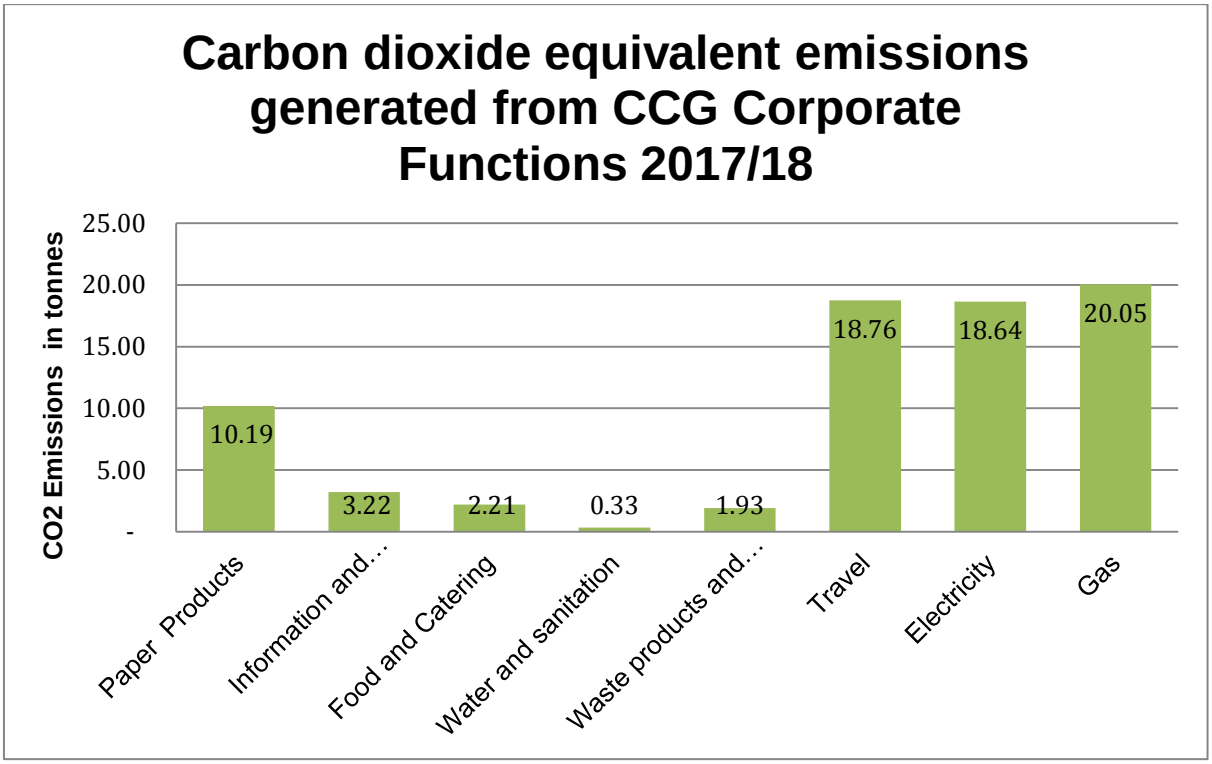
The specific impact of these is identified by area. The table below shows the changes between years:

| CO2 Emissions (tonnes of CO2e) | 2017/18 | 2016/17 | Change in tCO2e | % Change |
|---|---|---|---|---|
| Paper Products | 10.19 | 11.70 | -1.51 | -12.91% |
| Information and communication technologies | 3.22 | 5.55 | -2.33 | -41.98% |
| Food and Catering | 2.21 | 2.25 | -0.04 | -1.78% |
| Water and sanitation | 0.33 | 0.50 | -0.17 | -34.00% |
| Waste products and recycling | 1.93 | 1.92 | 0.01 | 0.52% |
| Travel | 18.76 | 20.11 | -1.35 | -6.71% |
| Electricity | 18.64 | 29.11 | -10.47 | -35.97% |
| Gas | 20.05 | 18.47 | 1.58 | 8.55% |
| | | | | |
| | | | | |
| **Total** | **75.33** | **89.61** | -14.28 | -15.94% |

The reductions in emissions relating to energy (Gas, Electricity) are as a result of the decreased expenditure on these areas attributed to the CCG between the two financial years. The reduction in emissions relating to paper products can be attributed to the continued extension of our paperless approach to working. The emissions relating to ICT have reduced against the prior year despite investment in technology to support paperless working. This is due to the 2016/17 figures including expenditure on items on behalf of other organisations who had staff hosted by the CCG. These costs were reimbursed in year.

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

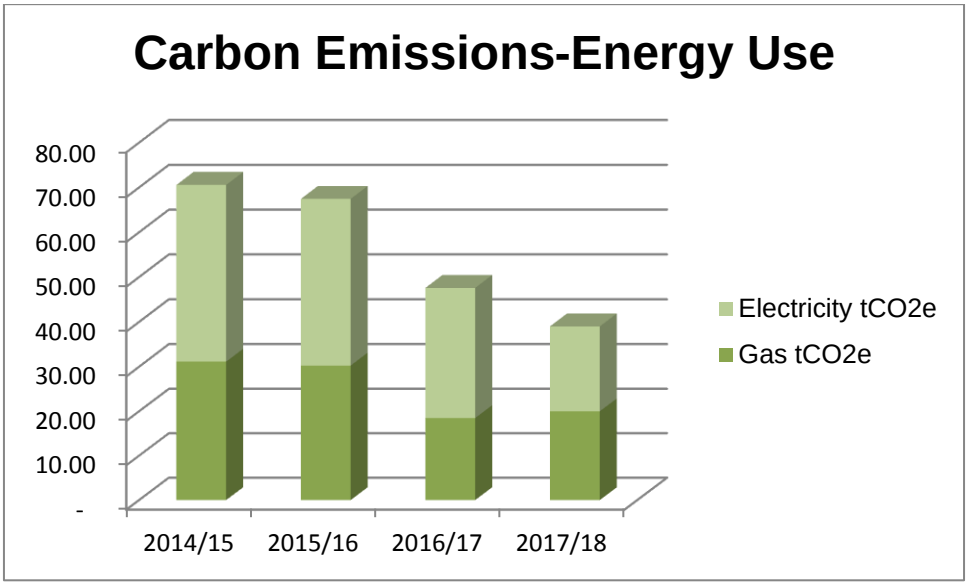
The chart below illustrates the carbon impact of our actions as a corporate body during 2017/18.




**Energy:**

The table below and following chart show our expenditure on energy for 2017/18 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 clear reduction in consumption of electricity in year. Overall, the carbon emissions associated with the CCG's energy usage are lower in 2017/18 than in 2016/17 by approximately 4%.

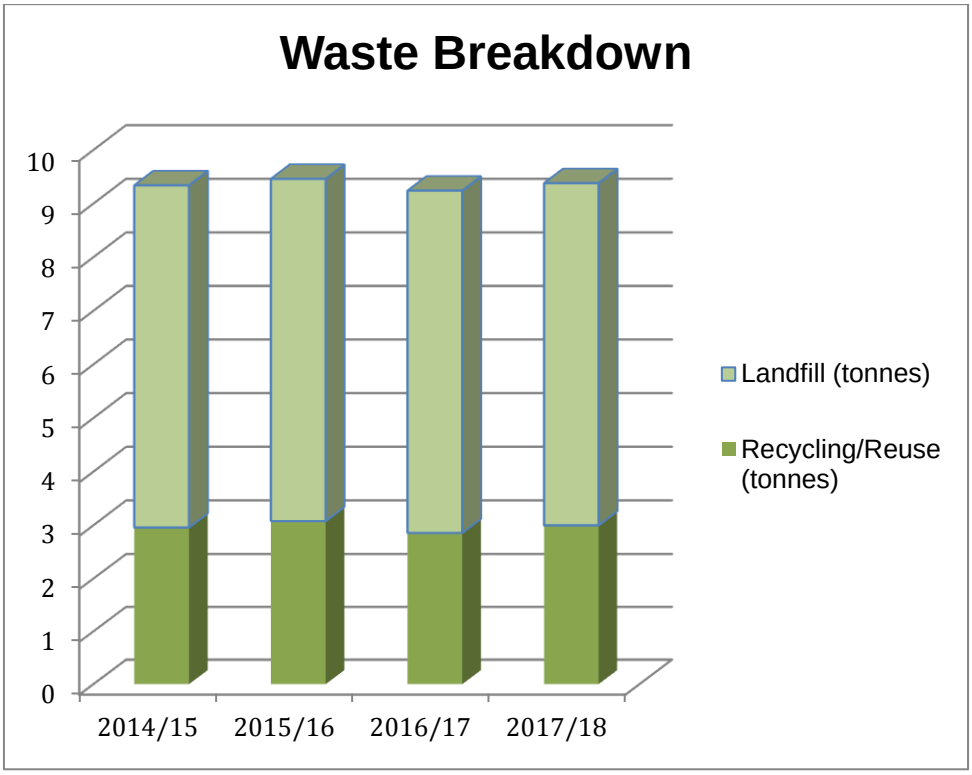
| Resource | | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Gas | Use (kWh) | 148,388 | 144,586 | 88,393 | 94,549 |
| | tCO2e | 31.13 | 30.26 | 18.47 | 20.00 |
| Electricity | Use (kWh) | 63,664 | 64,673 | 56,330 | 41,822 |
| | tCO2e | 39.43 | 37.18 | 29.11 | 19.00 |
| Total Energy tCO2e | | 70.56 | 67.44 | 47.58 | 39.00 |
| Total Energy Spend | | 11,663 | 10,103 | 7,948 | 7,622 |




**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 increase in total volume of waste. This is due to an overall increase in cost of recycling. Our percentage of waste recycled has improved slightly following a dip last year attributable to our reduced use of paper.

| **Waste** | | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| **Recycling/Reuse** | (tonnes) | 2.96 | 3.08 | 2.86 | 3.00 |
| | tCO2e | 0.06 | 0.06 | 0.06 | 0.07 |
| Landfill | (tonnes) | 6.38 | 6.38 | 6.38 | 6.38 |
| | tCO2e | 1.56 | 1.56 | 1.86 | 1.86 |
| Total Waste (tonnes) | | 9.34 | 9.46 | 9.24 | 9.38 |
| % Recycled or Re-used | | 31.69% | 32.56% | 30.95% | 31.98% |
| **Total Waste tCO2e** | | **1.62** | **1.62** | **1.92** | **1.93** |




**Water:**

The table below shows our expenditure on water and sewerage during 2017/18 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 a decrease in water consumption between 2016/17 and 2017/18.

| Water | | 2014/15 | 2015/16 | 2016/17 | 2017/18 |
|---|---|---|---|---|---|
| Mains | m3 | 695 | 306 | 548 | 360 |
| | tCO2e | 0.63 | 0.28 | 0.50 | 0.33 |
| Water & Sewage Spend | | £2,737 | £1,103 | £1,979 | £1,014 |

**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 North Bristol NHS Trust has achieved an excellent score for their sustainability reporting and that Royal United Hospitals Bath NHS FT has achieved a good score. In contrast other major providers have a poor score. These two acute providers, University Hospitals Bristol NHS FT and the South West Ambulance Service NHS FT 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.

## Financial review

The CCG has achieved its statutory financial duty for the year in achieving a surplus position. The final reported surplus position is as shown below:

| | £000 |
|---|---|
| Operational Surplus for the 2017/8 year | 99 |
| National Prescribing Rebate | 232 |
| National 0.5% Risk Reserve | 1,140 |
| Reported Surplus for the 2017/18 year | 1,471 |

As set out in the 2017/18 NHS Planning Guidance, CCGs were required to hold a 0.5% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. In compliance with the national requirement for use of this, NHS Bath and North East Somerset CCG has released its 0.5% reserve to the reported position for the year as shown above. In addition the CCG has received a share of a national prescribing rebate which is also required to be released into the reported position, as shown above.

This nationally mandated treatment has the effect of making the CCG's financial position for the year appear more favourable than it is. Without it, we would have achieved the minimal surplus of £0.099m shown in the table.

We closed the year with a total resource limit budget of £259.796m and operated within our revenue resource budget for 2017/18.

Savings schemes of £11.60m had been planned in 2017/18, of which £7.70m were delivered against specified schemes together with £2.80m of additional savings identified elsewhere in the year against activities similar to the savings schemes (90% achievement). The savings delivered included schemes to reduce avoidable referrals and emergency visits to hospital, to reduce expenditure on drugs and to ensure healthcare packages best meet need. This released resources used to fund cost pressures and a range of investments during 2017/18 to support the savings delivery and overall CCG strategy.

The recurrent administration resource budget of £4.257m was underspent by £0.047m. This is mainly due to staffing vacancies arising during the year.

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

### Operational Financial Balance – Revenue Resource Limit, including Administration Costs

We are required to operate within our allocated Revenue Resource Limit and achieved this by delivering a surplus of £1.471m (including the 0.5% headroom risk reserve funding and prescribing rebate being released to the position).

| | **2017/18**[1] | 2016/17 |
|---|---|---|
| | **£000** | £000 |
| Performance for the year ended 31 March 2018: | | |
| Total Net Operating Cost for the Financial Year | **258,325** | 231,333 |
| Revenue Resource Limit | **259,796** | 233,649 |
| **Underspend Against Revenue Resource Limit** | **1,471** | 2,316 |

[1]*The Clinical Commissioning Group took on greater responsibility for delegated commissioning of Primary Medical Care on the 1st April 2017, this is reflected in the 2017-18 figures.*

**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 (CSU), 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.

| | **2017/18** | 2016/17 |
|---|---|---|
| | **£000** | £000 |
| Performance for the year ended 31 March 2018: | | |
| Administration Cost for the Financial Year | **4,210** | 4,150 |
| Administration allocation | **4,257** | 4,268 |
| **Underspend Against Allocation** | **47** | 118 |

**Better Payment Practice Code – Measure of Compliance**

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

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

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

| | **2017/18 Number** | **2017/18 £000** | 2016/17 Number | 2016/17 £000 |
|---|---|---|---|---|
| **Non-NHS Creditors** | | | | |
| Total bills paid in the year | **4,900** | **102,543** | 3,568 | 83,447 |
| Total bills paid within target | **4,834** | **101,826** | 3,425 | 81,953 |
| Percentage of bills paid within target | **98.65%** | **99.30%** | 95.99% | 98.21% |
| | | | | |
| **NHS Creditors** | | | | |
| Total bills paid in the year | **2,845** | **129,786** | 2,569 | 125,993 |
| Total bills paid within target | **2,824** | **129,759** | 2,466 | 124,815 |
| Percentage of bills paid within target | **99.26%** | **99.98%** | 95.99% | 99.07% |

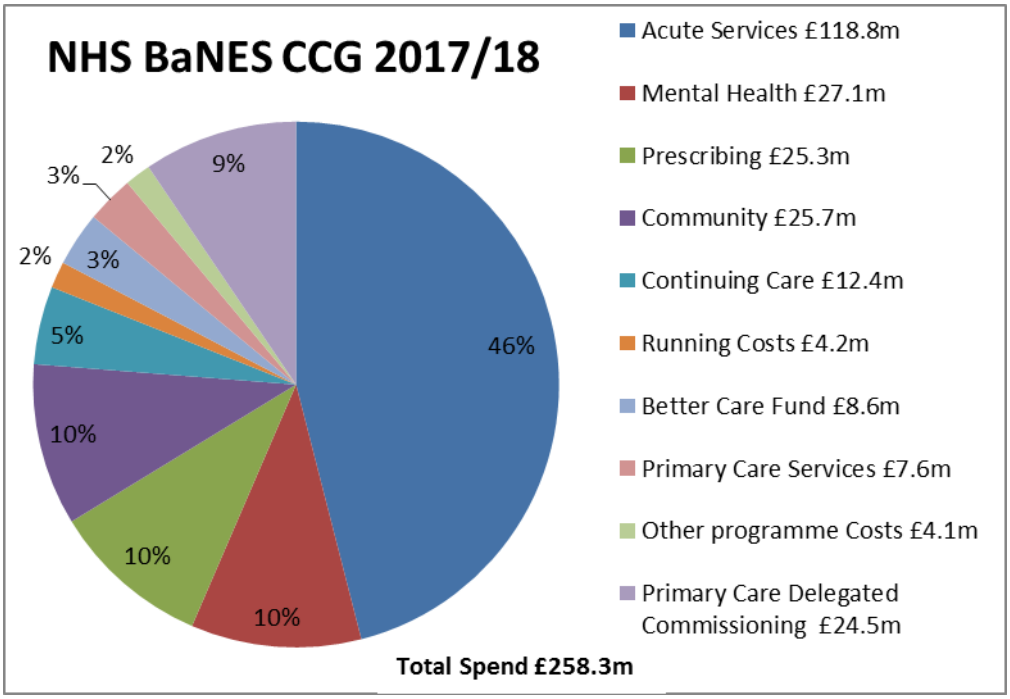
## Cash position

Our financial statements show cash held of £0.079m as at 31 March 2018. The CCG was required to have a balance no greater than 1.25% of the cash value drawn down in March, which equates to £0.238m and therefore the CCG has successfully met this target.

## CCG expenditure by category

We spend money on a range of healthcare services commissioned for the population of B&NES. The chart below shows the types of services provided and illustrates how much we spent on each during 2017/18. Acute healthcare makes up the highest percentage of expenditure (46%), with the next largest areas of expenditure being Primary Care (including Delegated Commissioning) followed by Prescribing, Mental Health (including Learning Disability) and Community Services which are all similar in value. The Primary Care spend has increased in 2017/18 following our approval under delegated commissioning arrangements from 1st April 2017 to assume full responsibility for contractual GP performance management, budget management and the design of local incentive schemes

In line with the CCG strategy, we envisage a continued ambition to shift healthcare spend from Acute Healthcare to Primary Care and Community settings as care pathways are redeveloped and services reviewed.




## Future Financial Position

The CCG has submitted a financial plan for 2018/19 which plans to deliver a breakeven position. Planned net savings of £5,673k 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

The CCG's main financial statements for 2017/18 are summarised overleaf. 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.

# ACCOUNTABILITY REPORT

**Signed:**

**Tracey Cox**
**Accountable Officer**
24 May 2018

# Corporate Governance Report

## Members 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.

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

### Member profiles

Please see Board member profiles on our website.
http://www.bathandnortheastsomersetccg.nhs.uk/about

### 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 Governing Body (known as the Board)

***The membership of our Board during 2017/18 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<br>*01/04/17 – 02/07/17* | Director of Nursing & Quality / Registered Nurse |
| Val Janson<br>03/07/17 – 03/09/17 | Interim Director of Nursing & Quality / Registered Nurse |
| Lisa Harvey<br>*04/09/17 to present* | Director of Nursing & Quality / Registered Nurse |
| Sarah James | Chief Financial Officer |
| Dr Tim Sephton | GP |
| Dr Elizabeth Hersch | GP |
| Dr Jonathan Osborn<br>*01/04/17 – 28/09/17* | GP |
| Dr Daisy Curling | Sessional GP |
| Helen Harris<br>*01/04/17 – 31/08/17* | Practice Manager |
| John Moon<br>*01/10/17 to present* | Practice Manager |
| John Holden | Lay Member (audit and governance) / Vice Chair |
| Suzannah Power | Lay Member (patient and public involvement) |
| Katie Hall | Lay Member (quality) |
| Myles Taylor<br>*01/04/17 – 09/11/17* | Secondary Care Specialist Consultant |
| **Members In Attendance (non-voting)** | |
| Julie-Anne Wales | Head of Corporate Governance & Planning |
| Corinne Edwards | Director of Acute and Primary Care Commissioning |
| Mike Bowden | Strategic Director People & Communities, B&NES Council |
| Bruce Laurence | Director Public Health, B&NES Council |
| Jane Shayler | Director, Integrated Health & Care Commissioning<br>(BaNES CCG & B&NES Council) |

**Chair and Chief Officer (Accountable Officer)**

The Clinical Chair of the CCG from 1 April 2017, 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 2017, throughout the year and up to the signing of the Annual Report and Accounts was Tracey Cox.

**Committee(s), including Audit Committee**

Throughout 2017/18 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).
- Primary Care 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 64-71.

**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 by NHS Protect in July 2017 and by Deloitte on behalf of NHS England in November 2017. Both audits provided the CCG with assurance of compliance for the management of conflicts of interest. The NHS Protect audit rated the CCG as green with no recommendations, and the NHS review identified minor recommendations for improvement.

## Personal data related incidents

There were no personal data related incidents that were formally reported to the Information Commissioner's Office during 2017/18.

## 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; and,

- Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable

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**
**24 May 2018**

# Governance Statement

## Introduction and context

Bath & North East Somerset 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 2017, 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 governing body is to ensure that the group 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.

**The Constitution**

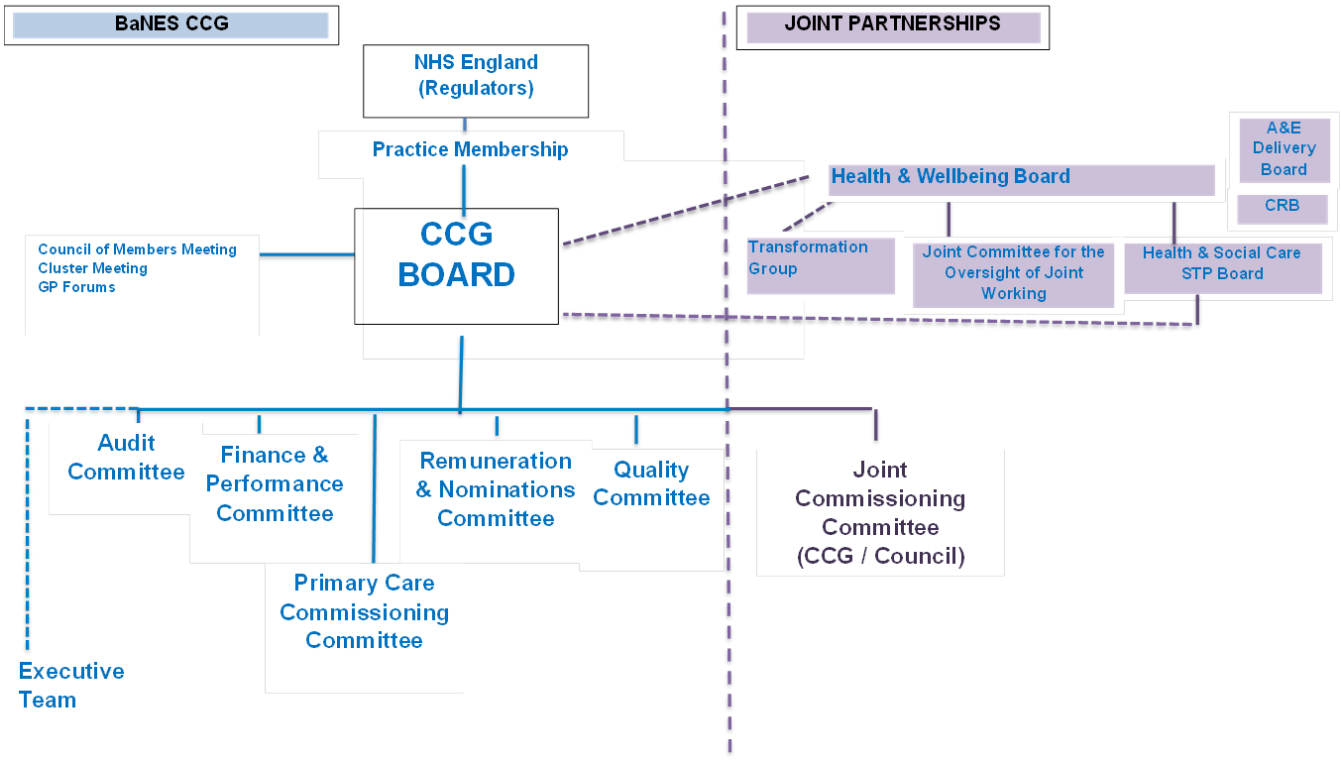
CCGs are legally obliged to set out their agreed governance arrangements in a publically available Constitution. The Constitution sets the 'ground rules' for the relationship between the Board and its members, as well as outlining the functions of the CCG and its constituent groups.

BaNES CCG Constitution is constructed around the exemplar model constitution provided by NHS England. During 2017/18 the Constitution was subject to amendment following engagement and consultation with member practices due to the move from primary care co-commissioning to fully delegated commissioning arrangements from 1 April 2017 which included the replacement of the Joint Primary Care Commissioning Committee with the Primary Care Commissioning Committee.

This change 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 49) 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. During 2017/18 the Council of Members met on two occasions and held three ballots as follows:-

| *Meetings/Votes* | | |
|---|---|---|
| ***Date*** | ***Item*** | ***Action*** |
| ***Meeting – 16 May 2017*** | Presentation of Annual Report & Accounts 2016/2017 | Delegated authority for the CCG Board to approve on recommendation of the Audit Committee |
| ***Meeting – 21 March 2018*** | Presentation of Draft Operational Plan 2018/19 | Delegated authority for the CCG Board to approve the final Plan on recommendation of the Finance & Performance Committee |
| **Electronic vote – July 2017** | Vote : Election of Practice Manager Board Representative | Appointment of John Moon as Practice Manager Board Representative |

Attendance at meetings during 2017/18 was in the range of 96-98 per cent.

## The CCG Board

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

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 May 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 pages 64-71.

In April 2017 the CCG moved from co-commissioning to fully delegated commissioning for Primary Care. As a result the Primary Care Commissioning Committee was established which replaced the Joint Primary Care Co-Commissioning Committee.

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

**The Board's performance and effectiveness**

An annual work-plan was set in May 2017 which covered the following key areas:-

- Oversight and delivery of the Operating Plan
- Reporting on and oversight of CCG finances and the financial recovery plan
- Reporting on and oversight on performance and quality issues within commissioned health providers
- Reporting on patient and public engagement in the work of the CCG
- Commissioning and strategy opportunities with local commissioners, providers and Local Authority
- The management of strategic risk through scrutiny of the Governing Body Assurance Framework (BAF) and the Risk Register
- Development of Primary Care Strategy
- Minutes and reports from the committees of the Board.

The Governing Body has performed well throughout the year, providing clear strategic leadership and accountability for the organisations' business and activities, in what was a challenging year in terms of organisational, financial, demand and operational pressures action on the healthcare system.

It has clear governance arrangements in place, with oversight from the Chair and the Audit Committee. Key decision in 2017/18 were around integration arrangements with B&NES Council, the 2 year Operational Development Plan, Commissioning

Policies and procurement decisions for the Integrated Urgent Care Service, NHS111, GP Out of Hours, Urgent Treatment Centre and the Homeless Healthcare service.

The ongoing bi-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 2017/18 was future strategic approach and risk appetite in the context of growing financial pressures faced by the CCG and the future of local commissioning and strategic commissioning. Items discussed in confidence included 2017/18 commissioning plans, financial matters, capacity and succession planning, procurement decisions, future strategic approach and safeguarding.

The Board met 8 times in public during the year; two of these meetings were Extraordinary meetings, one in September 2017 which was a joint Board meeting formed between BaNES, Wiltshire & Swindon CCGs and Wiltshire Council due to a joint procurement exercise, and one in March 2018 to discuss commissioning policies as referenced on page 16.

Papers are published on our website for all our Board meetings held in public.

Attendance at Board meetings and Board Seminars in 2017/18 can be seen on page 63.

**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.

A number of changes in Board membership occurred during 2017 which included a new Director of Nursing & Quality and Practice Manager Board representative. An

effective induction programme tailored to individual needs was completed, together with opportunities for the remainder of the Board to update their skills and experience during the year.

Due to the number of changes to the Board it has been agreed to undertake an external Board effectiveness review which will lead into a robust development plan to ensure the Board will be fit for the future.  The initial step to observe the Board took place in March 2018, with the other elements of 1-1 interviews, on-line survey and a Board Development Workshop taking place in May 2018.

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, enhancing the experience of people using services, reducing unacceptable variation in delivery and outcomes, underpinned by strong and effective systems, financial management and probity.

There was also a successful and well attended Annual General Meeting held on 27 July 2017 at which we presented our Annual Report and Accounts for 2016/17.

Board membership at meetings for 2017/18 is shown below:-

| | | Membership of Board Committees | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Name | Position | Board | Audit Committee | Finance & Performance | Joint Commissioning | Primary Care Commissioning Committee | Quality Committee | Remuneration Committee |
| **Elected Board Voting Members** | | | | | | | | |
| Dr Ian Orpen | Clinical Chair | 7/7 | n/a | 8/10 | n/a | n/a | n/a | 2/2 |
| Dr Ruth Grabham | Medical Director | 5/7 | n/a | 4/10*** | 7/11 | 3/4 | 4/7 | n/a |
| Dr Liz Hersch | GP Representative | 4/7 | n/a | n/a | 11/11 | n/a | n/a | n/a |
| Dr Daisy Curling | GP Representative | 3/7 | n/a | n/a | 11/11 | n/a | 6/7 | n/a |
| Dr Tim Sephton | GP Representative | 5/7 | n/a | n/a | 11/11 | n/a | n/a | n/a |
| Dr Jonathan Osborn | GP Representative | 4/4** | n/a | n/a | 4/5 | n/a | n/a | n/a |
| Helen Harris | Practice Manager Representative | 2/2 | n/a | n/a | 4/4 | 2/2 | n/a | n/a |
| John Moon | Practice Manager Representative | 2/4 | n/a | n/a | 6/7 | 2/2 | n/a | n/a |
| **Appointed Board Voting Members** | | | | | | | | |
| Tracey Cox | Chief Officer | 6/7 | 5/6 | 9/10 | 7/11 | n/a | 4/7 | n/a |
| Sarah James | Chief Financial Officer | 8/8** | 6/6 | 9/10* | 8/11 | 3/4* | n/a | n/a |
| Dawn Clarke | Director of Nursing & Quality / Registered Nurse | 1/2 | 2/2 | 3/4 | 2/4 | 1/1 | 2/2 | n/a |
| Lisa Harvey | Director of Nursing & Quality / Registered Nurse | 6/6** | 2/3* | 4/6 | 7/7 | 2/2 | 2/3* | n/a |
| Val Janson | Interim Director of Nursing & Quality / Registered Nurse | 1/1 | 0/1 | 0/1 | 1/1 | 1/1 | 1/1 | n/a |
| John Holden | Lay member | 8/8** | 6/6 | 9/10 | n/a | 4/4 | n/a | 3/3 |
| Suzannah Power | Lay member | 7/7 | 3/6 | n/a | n/a | 4/4 | 7/7 | 2/3 |
| Katie Hall | Lay member | 8/8** | 6/6 | n/a | n/a | 3/4 | 7/7 | 2/2 |
| Myles Taylor | Specialist Care Secondary Consultant | 1/4* | n/a | n/a | n/a | n/a | n/a | n/a |
| **Non-Voting Board Members** | | | | | | | | |
| Corinne Edwards | Director of Acute & Primary Care Commissioning | 6/7 | n/a | 9/10 | 10/11 | 4/4 | n/a | n/a |
| Jane Shayler | Director, Integrated Health & Care Commissioning, B&NES Council & BaNES CCG | 6/7 | n/a | 6/10 | 8/10 | n/a | n/a | n/a |
| Julie-Anne Wales | Head of Corporate Governance & Planning | 6/7 | 4/6 | 7/10 | | n/a | n/a | |
| Mike Bowden | Strategic Director People & Communities, B&NES Council | 4/7 | n/a | n/a | 7/11 | n/a | n/a | n/a |
| Bruce Laurence | Director of Public Health, B&NES Council | 4/7 | n/a | n/a | 7/11 | n/a | n/a | n/a |

*Deputy present

NB There were 7 CCG Board meetings and 1 Joint CCGs/LAs Board meeting therefore ** Indicates attendance at the Joint Extraordinary Meeting with Wiltshire, Swindon CCGs and Wiltshire LA

***Some meetings held on non-working days

## 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 and external audit and counter-fraud functions are in place, reviewing the work and findings of auditors and the CCG's response and monitoring the arrangements for and outputs of the CCG's financial reporting systems.

During 2017/18 the CCG undertook a joint procurement process with Gloucestershire CCG, Swindon CCG, Wiltshire CCG, 2gether NHS FT, Gloucestershire Hospitals NHS FT to re-commission the provision of Internal Audit Services. The contract for BaNES CCG was awarded to KPMG LLP.

During 2017/18 to CCG undertook a joint procurement process with Swindon CCG for the provision of counter-fraud and security management services. The contracts for BaNES CCG were awarded to TIAA Ltd.

The membership of the Audit Committee in 2017/18 was as follows:-

| Audit Committee Members and those in regular attendance | |
|---|---|
| **Members** | |
| **John Holden** | Committee Chair and Lay Member (audit and governance) |
| **Suzannah Power** | Lay Member (patient and public involvement) Committee Member |
| **Katie Hall** | Lay Member (quality) Committee Member |
| **In Attendance** | |
| **Tracey Cox** | Chief Officer |
| **Sarah James** | Chief Financial Officer |
| **Dawn Clarke** ***(01/04/17 – 02/07/17)*** | Director of Nursing & Quality |
| **Lisa Harvey** ***(04/09/17 to present)*** | Director of Nursing & Quality |
| **External Audit Representative** | Grant Thornton |
| **Internal Audit Representative** | KPMG |
| **Counter Fraud and Security Management specialists** | TIAA |

Attendance at Audit Committee meetings in 2017/18 can be seen on page 63.

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 risk register |
| • Reviewed findings of internal audit reports: CHC Follow Up Report, Core Financial Systems, Financial Forecasting Report, Conflicts of Interest, Staff Survey & Efficiency Report, Risk Management, Payroll Processes, Quality Assurance, Core Financial Systems, Information Governance Toolkit & Cyber Security Follow-up Review |
| • 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 May 2017. The committee also completed an annual self-assessment in 2017.

### Remuneration Committee

The CCG has a Remuneration Committee, the role of which is to make recommendations on the remuneration and conditions of senior staff, and to approve remuneration and conditions of service of Board members and to support the evaluation of the performance of members of the Board.

Membership of the Remuneration Committee in 2017/18 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 2017/18 three meetings of the CCG Remuneration Committee were held. At the June 2017 meeting the decision was made to award Board members a 1% pay uplift in line with Agenda for Change staff.

The attendance at the Remuneration Committee for 2016/17 can be seen on page 65.

### Quality Committee

This committee is responsible for overseeing quality across all commissioned services, ensuring high quality services which are clinically effective, safe and provide a positive patient experience. The committee ensures there is 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 across the system. The Quality Committee identified themes and trends in quality, patient safety and patient experience and ensures any risks to patient safety are identified early and managed effectively.

The members of the Quality Committee during 2017/18 were:-

| Quality Committee Members (voting) | |
|---|---|
| **Katie Hall** | Committee Chair and Lay Member (Quality) |
| **Dawn Clarke** ***(01/04/17 – 02/07/17)*** | Director of Nursing & Quality / Registered Nurse |
| **Lisa Harvey** ***(04/09/17 to present)*** | Director of Nursing & Quality / Registered Nurse |
| **Dr Ruth Grabham** | Medical Director |
| **Dr Daisy Curling** | GP |
| **Tracey Cox** | Chief Officer |
| **Suzannah Power** | Lay Member (patient and public involvement) |
| **A Public Health Representative** | |
| **Representative from Healthwatch** | |

Attendance at Quality Committee in 2017/18 can be seen on page 63.

During 2017/18, 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 the CCG Safeguarding and Continuing Healthcare policies, and provided the necessary oversight for a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness, patient experience, medicines Optimisation and safeguarding.

## Joint Commissioning Committee

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

The Joint Commissioning Committee membership in 2017/18 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** ***(01/04/17 – 02/07/17)*** | Director of Nursing & Quality |
| **Lisa Harvey** ***(04/09/17 to present)*** | Director of Nursing & Quality |
| **Corinne Edwards** | Director of Acute and Primary Care Commissioning |
| **Council Members** | |
| **Mike Bowden** | 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** ***(01/04/17 – 28/02/18))*** | People & Communities, Finance Manager B&NES Council |
| **Tammy Randall** ***(01/03/18 – present))*** | People & Communities, Finance Manager B&NES Council |
| **Clinical Members** | |
| **Dr Tim Sephton** | **GP** |
| **Dr Elizabeth Hersch** | **GP** |
| **Dr Jonathan Osborn (01/04/17 – 28/09/17)** | **GP** |
| **Dr Daisy Curling** | **GP** |
| **Helen Harris (01/04/17 – 31/08/17)** | **Practice Manager** |
| **John Moon (01/10/17 to present)** | **Practice Manager** |

The committee receives a number of regular reports: the Joint Partnership Risk Register; the Integrated Quality and Performance Report; Finance and savings programme reports from the CCG and Council. The Committee also reviews savings plans for the forthcoming year.

Significant areas of business discussed by the Joint Commissioning Committee during the year were:-

| Clinical | Joint Commissioning | Joint Business |
|---|---|---|
| • Community Dermatology Service<br>• Pain Management Service<br>• RSS Development<br>• Integrated Urgent Care Procurement<br>• Virgin Care Transition<br>• Business Case for Dietetic Services | • Joint Assessment Panel Annual Report<br>• IFR Annual Report<br>• Appeals Policy<br>• IRF Policies to align with STP<br>• Violence Against Women and Girls Transformation Bid<br>• Joint Working Framework<br>• Operational Plans 2017/18 | • Business Continuity Plan<br>• Better Care Fund (BFC) Plans 2017/18<br>• EPRR self-assurance for 2017/18<br>• Various HR Policies<br>• The Sufficiency Statement – Looked After Children Placements in the Independent Sector |

| | | |
|---|---|---|
| • DVT Service<br>• Map Of Medicine<br>• Health Optimisation Pathway<br>• Home First 7 Day Discharge Provision<br>• Hone First Pathway Three (Beds)<br>• Community Hospital Review<br>• Fracture Support Pathway Audiology Service<br>• Fertility Service<br>• Sterilisation Service<br>• Maternity Redesign<br>• CAMHS Transformation Plans 2017/18<br>• Falls Rapid Response Team<br>• Acute Paediatric Front Door Management Pilot<br>• Mental Health Pathway<br>• Domestic Violence Services<br>• Living with and beyond cancer tariff<br>• Low Priority Prescribable Items<br>• Business Case Medicine Management Reduction<br>• Homeless Healthcare Service<br>• Enhanced Hospice at Home Service<br>• Community Frailty<br>• Medicines Optimisation in Care Homes<br>• Business Case Non Emergency Patient Transport Service | • Market Position Statement for Adult Social Care<br>• B&NES Domestic Abuse Strategy | • Sustainability action plan<br>• Funding for Supported Housing |

Attendance at the Joint Commissioning Committee in 2017/18 can be seen on page 63.

## Primary Care Commissioning Committee (PCCC)

Membership of the Primary Care Commissioning Committee in 2017/18 was as follows:-

| **Primary Care Commissioning Committee Voting Members** | |
|---|---|
| CCG Members | |
| **Suzannah Power – Chair** | Lay member |
| **Dawn Clarke** ***(01/04/17 – 02/07/17)*** | Director of Nursing & Quality |
| **Lisa Harvey** ***(04/09/17 to present)*** | Director of Nursing & Quality |
| **Corinne Edwards** | Director of Acute and Primary Care Commissioning |
| **Dr Ruth Grabham** | Medical Director and GP Representative |
| **Helen Harris (01/04/17 – 31/08/17)** | Practice Manager |
| **John Moon (01/10/17 to present)** | Practice Manager |
| **John Holden** | Lay Member |
| **Katie Hall** | Lay Member |
| **Sarah James** | Chief Financial Officer |

| Non-Voting Members | |
|---|---|
| **Debra Elliot** | Director of Commissioning, South Central, NHSE |
| **Nikki Holmes** | Head of Primary Care, South Central, NHS England |
| **John Trevains** | Assistant Director of Nursing, Quality & Safety, South Central, NHSE |
| **Dean Walton** | Senior Finance Manager, South Central, NHSE |
| **Dr Gareth Bryant** | LMC Representative |
| **Alex Francis** | Healthwatch BANES Team Manager |
| **Cllr Vic Pritchard** | Cabinet Member for Adult Social Care and Health, BaNES Council |
| **Rebecca Reynolds** | Consultant in Public Health, BaNES Council |
| **James Childs-Evans** | Senior Commissioning Manager for Primary Care, BaNES CCG |
| **John Fogg** | Senior Finance Manager (non-acute services) BaNES CCG |
| **Daisy Picking** | PPI Manager, BaNES CCG |
| **Tamsin May** | Head of Communications, BaNES CCG |

Attendance at the Primary Care Co-Commissioning Committee can be seen on page 63.

As part of the requirements to move to fully Delegated Commissioning arrangements the CCG established a Primary Care Commissioning Committee as a sub-committee of the Board with responsibility for commissioning primary medical services for the people of Bath and North East Somerset, under Section 83 of the NHS Act on 1 April 2017

GP members are excluded from Committee discussions and decisions regarding topics where they have a conflict of interest.

The functions upon which the Committee has made decisions over 2017/18 include:

- Enhanced Services and Local Incentive Schemes;
- Formal establishment of mergers between practices in line with our objectives;
- Supporting the closure of two GP practices and one outlying clinic;
- Various discretionary payments under the GP Resilience Funding and GP Development Programme budgets;
- Design and content of a Primary Care Strategy as an update to the Primary Care Statement of Intent;
- Primary Medical Service Planning;
- Reviews of primary medical care services;
- Approving submissions to NHSE for capital investments in primary care;
- Decisions in relation to the management of poorly performing GP practices;

- Management of delegated funds;
- Development of a new quality in primary care dashboard.

The Primary Care Commissioning Committee oversees the work of the Primary Care Operational Group and the primary care work plans established by the CCG as part of the Five Year Forward View strategy and the General Practice Forward View Plan. During this year the Committee had input into the content of the Primary Care Engagement Survey which has provided significant data on patient preferences around access and booking of GP appointments.

The Committee has worked hard to ensure progress on the transition plan which supports the full transfer of responsibility from NHS England to the CCG for Primary Medical Service commissioning this year, and we look forward to continued good progress and full delegation of responsibilities in October 2018.

### Finance & Performance Committee

This Finance & Performance Committee provides a robust performance framework which proactively manages the CCG's financial, performance and improving value schemes.

The membership of the Finance & Performance Committee for 2017/18 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** ***(01/04/17 – 02/07/17)*** | Director of Nursing & Quality |
| **Lisa Harvey** ***(04/09/17 to present)*** | Director of Nursing & Quality |
| **John Holden** | Lay Member (Audit & Governance) |
| **Corinne Edwards** | Director of Acute and Primary Care Commissioning |
| **Julie-Anne Wales** | Head of Corporate Governance & Planning |
| **Jane Shayler** | Director, Integrated Health & Care Commissioning |

Attendance at the Finance & Performance Committee in 2017/18 can be seen on page 63.

Key significant areas of business discussed by the Finance & Performance Committee during 2017/18 were the financial recovery, contract performance,

monitoring of improving value schemes, Better Care Fund, investments for 2017/18, and budgets for 2017/18.

**Joint Working Framework**

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

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 at the following link: http://www.bathnes.gov.uk/sites/default/files/banes_health_and_wellbeing_strategy_2015_-_2019.pdf.

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.

In November 2017, the Board set out a shared ambition to integrate further with B&NES Council to seamlessly plan, commission and deliver better quality services in order to improve the health and care of the population of Bath and North East Somerset. In order to facilitate this arrangement we have established an Integration Steering Group which is supported by four workstreams: Governance, Communications & Engagement; Organisational Development, and, Finance and Infrastructure. We plan to establish a new Health and Care Board (HCB) in interim form from May 2018.

**Better Care Fund**

The CCG and Council agreed a 2 year Better Care Fund plan for 2017-19 which included a number of jointly funded new schemes and initiatives. In 2017, the new community health and care contract also became part of the Better Care Fund, demonstrating both the CCG and Council's commitment to integrated working and improved outcomes for the people of B&NES. The Better Care Fund plan also included investments funded by a new government grant (the Improved Better Care Fund) designed to help increase the numbers of people getting home from hospital,

preventing any unnecessary admissions into hospital and supporting local care providers. New schemes this year included the Falls Rapid Response Service, a joint OT-Paramedic service in the community, Discharge to Assess beds at a local care home giving people extra rehabilitation outside hospital, and seven day access to Home First, the service that helps people go home from hospital as soon as they are ready. Already schemes are helping to reduce the numbers of people delayed in hospital unnecessarily and helping people to be treated at home where possible and appropriate.

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

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the 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. A new Board Assurance Framework was introduced in 2017/18 with a simplified format with 3

overarching objectives: financial sustainability, transforming services and business as usual. The new framework takes into account our risk appetite and 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. The new framework has the approval of our auditors.

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 development of an action plan. Progress was reported regularly to the Audit Committee and the Board. This Framework will be reviewed for 2018/19 but many of the objectives and risks will continue into next year.

We have updated our risk management strategy in 2017/18 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 2017/18. 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 substantial 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 2017/18 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 2017/18 were: Achieving Financial Sustainability; Transforming Services and Business as Usual.

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:

- Description of risk
- Classification of risk
- Risk rating
- Existing Controls and proposed action/ controls measures
- RAG against progress and commentary on status of action plans
- Review date
- Movement in risk scores

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 2017/19 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 A&E 4 hour performance;
- Recovering referral to treatment access times;
- Contributing to the delivery of the STP programmes

Our risk profile has decreased during 2017/18 with eleven high scoring risks on the corporate risk register in May and November 2017. However, by the end of the financial year this had reduced to five corporate risks by March 2018.

The risks discussed by the Board, the Audit Committee and the Joint Commissioning Committee have consistently included financial risks and QIPP delivery; the performance of the urgent care system; delivery of the 4-hour waiting time target in A&E; referral to treatment times; and during the year, various risks such as non-emergency patient transport and waiting times for diagnostics.

## 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.

## Control Issues

*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 management of conflicts within the CCG were reviewed by NHS Protect in July 2017 and by Deloitte on behalf of NHS England in November 2017. Both audits provided the CCG with assurance of compliance for the management of conflicts of interest. The NHS Protect audit rated the CCG as green with no recommendations, and the NHS England review identified minor recommendations for improvement.

### 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 2017/18.

*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 an established information governance management

framework with a named Senior Information Risk Officer, Caldicott Guardian and an Information Governance Steering Group. We have well 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, with some individual elements scoring at level 3.

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

We received assurance as to our Information Governance framework through an internal audit of our toolkit submission. Our CSU has a dedicated IT Security Manager in post to safeguard the tools and technologies relied upon and provides quarterly updates with recommendations and responses to the National Carecert Advisories.

The CCG is prepared for the implementation of GDPR (General Data Protection Regulations) in May 2018.

*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*

We receive third party assurances in the form of Service Auditor Reports from the South, Central and West Commissioning Support Unit in respect of services provided to us, and from NHS England in respect of activities related to Delegated Primary Care Commissioning which they continue to carry out. These are reported to the Audit Committee. Relevant action plans in response to findings are also shared. We do not consider that any of the audit findings represent significant control issues for the CCG.

## Control Issues

The control issues currently facing the CCG are as follows:

| Control Issues | Action |
|---|---|
| Meeting NHS Constitutional Targets :<br>4 hours | A&E Delivery Board in place. CCG has led the development and implementation of a coherent strategy for urgent care across the system and a range of schemes, system management targets and a focus on patients with delays to discharge.<br><br>Quality assurance visits to A&E to assess the quality and safety of care provided at the busiest times during the winter period. |
| Meeting NHS Constitutional Targets : RTT | Arrangements made for individual patients approaching 52 week waits.<br><br>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 : Diagnostics - | Recovery plans in place with providers |
| Meeting NHS Constitutional Targets : Dementia diagnosis | Practice pharmacists have identified additional patients by re-running the search for patients on dementia drugs<br><br>Practices also re-running Data Quality Tool to see if this identifies any further patients |
| Delivery of our Meeting Financial performance targets | Financial recovery plan in place and achieved in 2017/18 |
| Improvement and Assessment Framework (IAF) – requires improvement status in Better Care domain | Work plan in place to secure required improvements. Frequent progress reports provided to NHSE. |

## 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. The Finance and Performance Committee undertakes detailed scrutiny of financial and contractual performance.

As the CCG's financial position has become more challenging, we have developed a comprehensive plan for financial recovery, to return us to a position of sustainable financial balance. Our successful delivery of this plan in 2017/18 has been possible as a result of our implementation of a rapid change of culture and pace in response to the emergent financial challenge. This has been achieved through a strong programme management approach to QIPP delivery driven by collective Board and Executive ownership and demonstrates strong leadership of the CCG. Delivery of the Financial Recovery Plan has been monitored by the Finance & Performance Committee in 2017/18.

The CCG is using the Resilience Handbook, Menus of Opportunities; QIPP Opportunity Guides and Rightcare benchmarking data; procurement and market testing; and individual service reviews 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.

We were randomly selected by NHS Protect for an audit of our counter-fraud arrangements during 2017/18 and were found to be 'green' in all areas reviewed, with no recommendations for further improvement.

# Head of Internal Audit Opinion 2017/18

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:

### *Basis of opinion for the period 1 April 2017 to 31 March 2018*

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards (PSIAS). As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000. PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

### *Roles and responsibilities*

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with PSIAS, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This opinion will in turn assist the Board in the completion of the AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

### *Opinion*

Our opinion is set out as follows:

- Basis for the opinion;
- Overall opinion; and
- Commentary.

#### *Basis for the Opinion*

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas.

*Overall Opinion*

Our opinion based for the period 1 April 2017 to 31 March 2018 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 2017 to 31 March 2018 inclusive, and is based on the nine audits that we completed during 2017/18.

**The design and operation of the Assurance Framework and associated processes**

Overall our review found that the Assurance framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Board.

The Assurance Framework reflects the organisation's key objectives and risks and is reviewed on a bi-monthly basis by the Board and bi-monthly by the Audit Committee. It was reviewed most recently by the Board on 29 March 2018.

**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 'partial with improvement required' or 'no' assurance ratings in respect of 2017/18 assignments. For the remaining reviews we issued two 'significant' assurance ratings and seven 'significant assurance with minor improvement opportunities' ratings. Our audits identified no high priority recommendations.

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

KPMG LLP
Chartered Accountants
Bristol

May 2018

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

| Area of Audit | Level of Assurance Given |
|---|---|
| Financial Reporting | Significant Assurance |
| Financial Forecasting | Significant Assurance |
| Staff Survey & Efficiency Report | Significant Assurance with minor improvements required |
| Risk Management | Significant Assurance with minor improvements required |
| Payroll Processes | Significant Assurance with minor improvements required |
| Quality Assurance | Significant Assurance with minor improvements required |
| Financial Systems | Significant Assurance with minor improvements required |
| Information Governance Toolkit & Cyber Security | Significant Assurance with minor improvements required |
| Primary Care Transformation | Significant Assurance with minor improvements required |

## 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 Primary Care 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 2017/18. 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 – Good. This Better Care rating relates

predominantly to the difficulties in delivering the 4 hour waiting time target in A&E in our local health system.  A Cat 4 System Urgent Care Recovery Plan has been prepared and is being implemented.

**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.

# Remuneration and Staff Report

## Remuneration Report

**Remuneration Committee**

Please see details of the Remuneration Committee in the Director's Report (page 65).

**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 VSM and Board members' salaries 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 £150,000 per annum.

**Senior manager remuneration (including salary and pension entitlements) 2017/18**

*NHS Bath and North East Somerset Clinical Commissioning Group - remuneration of senior managers 2017-18 - 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 | £ | £000 | £000 | £000 | £000 |
| Dr Ian Orpen, Chair of the CCG | 01/04/2017 | Present | 90-95 | 200 | 0 | 0 | 0 | 90-95 |
| Dr Ruth Grabham, Medical Director | 01/04/2017 | Present | 85-90 | 0 | 0 | 0 | 10-12.5 | 95-100 |
| Tracey Cox, Chief Officer | 01/04/2017 | Present | 100-105 | 300 | 0 | 0 | 0 | 101-105 |
| Sarah James, Chief Financial Officer | 01/04/2017 | Present | 90-95 | 200 | 0 | 0 | 0 | 90-95 |
| Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member | 01/04/2017 | 02/07/2017 | 20-25 | 0 | 0 | 0 | 2.5-5 | 25-30 |
| Val Janson, Director of Nursing & Quality; Registered Nurse Member | 03/07/2017 | 03/09/2017 | 45-50 | 0 | 0 | 0 | 17.5-20 | 65-70 |
| Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member | 04/09/2017 | Present | 45-50 | 0 | 0 | 0 | 62.5-65 | 105-110 |
| Dr Elizabeth Hersch, GP Cluster Lead | 01/04/2017 | Present | 25-30 | 0 | 0 | 0 | 25-27.5 | 50-55 |
| Dr Daisy Curling, GP Cluster Lead | 01/04/2017 | Present | 25-30 | 0 | 0 | 0 | 5-7.5 | 30-35 |
| Dr Jonathan Osborn, GP Cluster Lead | 01/04/2017 | 28/09/2017 | 10-15 | 0 | 0 | 0 | 15-17.5 | 25-30 |
| Dr Timothy Sephton, GP Cluster Lead | 01/04/2017 | Present | 25-30 | 0 | 0 | 0 | 37.5-40 | 65-70 |
| Mr Myles Taylor, Secondary Care Representative | 01/04/2017 | Present | 0-5 | 0 | 0 | 0 | N/A | 0-5 |
| Helen Harris, Practice Manager Representative | 01/04/2017 | 31/08/2017 | 5-10 | 0 | 0 | 0 | N/A | 5-10 |
| John Moon, Practice Manager Representative | 01/10/2017 | Present | 5-10 | 0 | 0 | 0 | N/A | 5-10 |
| Katie Hall, Lay Member for Quality | 01/04/2017 | Present | 5-10 | 0 | 0 | 0 | N/A | 5-10 |
| John Holden, Lay Member for Audit and Governance | 01/04/2017 | Present | 15-20 | 100 | 0 | 0 | N/A | 15-20 |
| Suzannah Power, Lay Member for Patient and Public Involvement | 01/04/2017 | Present | 15-20 | 200 | 0 | 0 | N/A | 15-20 |

***Notes:***

*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 Helen Harris from Number 18 Surgery. 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 Katie Hall, John Holden and Suzannah Power*

*The CCG is unable to disclose pension details for Helen Harris and Mr Myles Taylor due to recharge arrangements.*

*The figures shown for Tracey Cox represent Tracey's total pay for the year excluding work for NHS Wiltshire CCG where she was Chief Officer until 31st May 2017. A salary recharge in the banding of £10-15k (excluding employer's National Insurance and Pension contributions) was made to NHS Wiltshire CCG during 2017-18.*

*The costs for Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Jonathan Osborn and Dr Timothy Sephton include remuneration for work completed for the CCG other than board duties, on commissioning and re-design of clinical services.*

*Where senior managers were in post for part of the financial year, figures relating to all pension related benefits have been calculated on a pro-rata basis to reflect the length of time in post.*

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

**For comparison the table below shows remuneration for senior managers for 2016/17 (Restated) - 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 Audit 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 onwards Dr Hampton was paid via payroll and figures reported for this period are for his salary only.

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 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 Pension contributions) was made during 2016-17 to NHS Wiltshire CCG during 2016-17.

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 per mile tax free amount set by HMRC. This is in line with Agenda for Change guidance on mileage payments.

All GP Members are now paid via payroll

# Pension Disclosure

***NHS Bath & North East Somerset Clinical Commissioning Group***

***Pensions Disclosure - 2017-18 - AUDITED:***

| 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 2018 (bands of £5,000) | (d) Lump sum at pension age related to accrued pension at 31st March 2018 (bands of £5,000) | (e) Cash Equivalent Transfer Value at 1 April 2017 | (f) Real increase in Cash Equivalent Transfer Value | (g) Cash Equivalent Transfer Value at 31 March 2018 | (h) Employer's contribution to stakeholder pension |
|---|---|---|---|---|---|---|---|---|
| | *£'000* | *£'000* | *£'000* | *£'000* | *£'000* | *£'000* | *£'000* | *£'000* |
| Dr Ian Orpen, Chair of the CCG | 0 | 0 | 10-15 | 30-35 | 247 | 0 | 250 | Nil |
| Dr Ruth Grabham, Medical Director | 0-2.5 | 2.5-5 | 20-25 | 60-65 | 390 | 33 | 426 | Nil |
| Tracey Cox, Chief Officer | 0 | 0 | 40-45 | 100-105 | 640 | 25 | 671 | Nil |
| Sarah James, Chief Financial Officer | 0 | 0 | 30-35 | 90-95 | 554 | 0 | 560 | Nil |
| Dawn Clarke, Director of Nursing & Quality; Registered Nurse Member | 0-2.5 | 0-2.5 | 20-25 | 65-70 | 444 | 11 | 490 | Nil |
| Val Janson, Director of Nursing & Quality; Registered Nurse Member (Interim) | 0-2.5 | 0 | 15-20 | 55-60 | 347 | 23 | 373 | Nil |
| Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member | 0-2.5 | 7.5-10 | 20-25 | 60-65 | 279 | 59 | 384 | Nil |
| Dr Elizabeth Hersch, GP Cluster Lead | 0-2.5 | 0-2.5 | 10-15 | 25-30 | 146 | 18 | 165 | Nil |
| Dr Daisy Curling, GP Cluster Lead | 0-2.5 | 0-2.5 | 10-15 | 30-35 | 147 | 16 | 164 | Nil |
| Dr Jonathan Osborn, GP Cluster Lead | 0-2.5 | 0-2.5 | 10-15 | 40-45 | 196 | 9 | 217 | Nil |
| Dr Timothy Sephton, GP Cluster Lead | 0-2.5 | 2.5-5 | 0-5 | 5-10 | 7 | 33 | 40 | Nil |

***Notes:***

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

*Mr Myles Taylor's pension contributions 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.*

*Where senior managers were in post for part of the financial year, figures relating to real increases in pension, lump sum and CETV have been calculated on a pro-rata basis to reflect the length of time in post.*

*The figures for Dr Ian Orpen, Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Jonathan Osborn and Dr Timothy Sephton 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).*

## For comparison the table below shows pensions for senior managers for 2016/17 – Audited

*NHS Bath & North East Somerset Clinical Commissioning Group*

*Pensions Disclosure - 2016 /17 - AUDITED:*

| 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 2017 (bands of £5,000) | (d) Lump sum at pension age related to accrued pension at 31st March 2017 (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 for April to June 2016 were paid via his practice - St Michael's Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.

Helen Harris' pension contributions 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 that they retire early.

## 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 that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

## Compensation on early retirement of for loss of office

There were no staff who took early retirement in 2017/18 due to ill health.

## Payments to past members

During 2017/18 there were no redundancies or other departure costs that have been paid in accordance with the provisions of the NHS Pension Scheme. There were no termination payments or payments made to past senior managers.

**Pay multiples 2017/18 – Audited**

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 2017/18 was £90,000 - £95,000 (2016/17: £85,000 - £90,000). Based on a whole time equivalent, this salary was in the band of £150,000 - £155,000 (2016/17: £150,000 - £155,000). This was 3.51 (2016/17: 3.69) times the median remuneration of the remainder of the workforce, which was £43,469 (2016/17: £41,373).

In 2017/18, 1 (2016/17: 1) 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 £155,000 - £160,000 (2016/17: £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 (2016/17: £15,000 - £20,000).

Full-time equivalent remuneration ranged from £18,000 to £156,000 (2016/17: £16,000 to £155,000).

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.

## Staff numbers and costs

**Staff Numbers and costs - Audited**

| | Recoveries in respect of employee benefits | | | |
|---|---|---|---|---|
| | 2017-18 | | | 2016-17 |
| | Total £'000 | Permanent employees £'000 | Other £'000 | Total £'000 |
| **Employee benefits - revenue** | | | | |
| Salaries and wages | (471) | (389) | (82) | (348) |
| Social security costs | (45) | (45) | 0 | (26) |
| Employer contributions to NHS Pension Scheme | (46) | (46) | 0 | (33) |
| Termination benefits | 0 | 0 | 0 | (18) |
| **Total recoveries in respect of employee benefits** | **(562)** | **(480)** | **(82)** | **(425)** |

The increase in costs and associated recoveries of employee benefits is mostly associated with the CCG hosting posts and recharging costs out in respect of STP and integration work-streams. The apprenticeships levy is a new charge for 2017-18.

| Employee benefits | 2017-18 | Total | | | Admin | | | Programme | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total £'000 | Permanent Employees £'000 | Other £'000 | Total £'000 | Permanent Employees £'000 | Other £'000 | Total £'000 | Permanent Employees £'000 | Other £'000 |
| Employee benefits | | | | | | | | | | |
| Salaries and wages | | 3,280 | 2,991 | 290 | 2,213 | 2,096 | 117 | 1,068 | 895 | 173 |
| Social security costs | | 338 | 325 | 12 | 240 | 231 | 9 | 97 | 95 | 3 |
| Employer Contributions to NHS Pension Scheme | | 412 | 399 | 13 | 289 | 278 | 11 | 123 | 121 | 2 |
| Termination benefits | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Apprenticeships Levy | | 1 | 1 | 0 | 1 | 1 | 0 | 0 | 0 | 0 |
| **Gross employee benefits expenditure** | | **4,031** | **3,716** | **315** | **2,743** | **2,606** | **137** | **1,287** | **1,110** | **177** |
| Less: recoveries in respect of employee benefits | | (562) | (480) | (82) | (347) | (347) | 0 | (216) | (134) | (82) |
| **Total - net employee beneftis including capitalised costs** | | **3,468** | **3,236** | **233** | **2,396** | **2,259** | **137** | **1,072** | **976** | **95** |
| Less: Employee costs capitalised | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | | **3,468** | **3,236** | **233** | **2,396** | **2,259** | **137** | **1,072** | **976** | **95** |

| Employee benefits | 2016-17 | Total | | | Admin | | | Programme | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total £'000 | Permanent Employees £'000 | Other £'000 | Total £'000 | Permanent Employees £'000 | Other £'000 | Total £'000 | Permanent Employees £'000 | Other £'000 |
| Employee benefits | | | | | | | | | | |
| Salaries and wages | | 3,131 | 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 employee beneftis 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** |

**Average number of people employed**

| | 2017-18 | | | 2016-17 |
|---|---|---|---|---|
| | Total Number | Permanently employed number | Other number | Total number |
| **Total** | **68** | **64** | **4** | **65** |

There are no people engaged on capital projects in either 2016-17 or 2017-18.

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 2018

### Staff Numbers

| Assignment Status | Headcount | FTE |
|---|---|---|
| Active Assignment | 83 | 65.95 |
| Internal Secondment | 1 | 1.00 |
| Maternity & Adoption | 1 | 0.53 |
| Out on External Secondment - Paid | 1 | 0.53 |
| Grand Total | 86 | 68.01 |

Included within the number of staff employed, are employees that NHS Bath and North East Somerset Clinical Commissioning Group hosts on behalf of other organisations. As at 31st March 2018, there are 13 staff (9.41 whole-time equivalents) where the CCG acts as a host employer and their salary, on-costs and expenses are recharged in full to other organisations. The majority of these posts are recharged to Bath & North East Somerset Council in respect of integration and transformation team posts and to the Bath and North East Somerset, Swindon and Wiltshire STP, whose project budget for 2017/18 was hosted by Great Western Hospitals NHS Foundation Trust, for a number of their staff.

### Number of Senior Managers by Band

| Band | Headcount | FTE |
|---|---|---|
| Band 8 - Range A | 17 | 13.20 |
| Band 8 - Range B | 8 | 7.13 |
| Band 8 - Range C | 9 | 7.63 |
| Band 8 - Range D | 3 | 2.60 |
| Other | 15 | 6.55 |

| Number of staff by gender | Female | Male |
|---|---|---|
| Part Time | 37 | 8 |
| Full Time | 37 | 10 |
| Board Members | 5 | 4 |
| VSM* | 3 | 0 |

*VSM = Very Senior Managers

# Sickness absence data

Sickness absence data is provided in the table below.

| Sickness absence | 2017-18 Number | 2016-17 Number |
|---|---|---|
| Total Days Lost[1] | 163 | 266 |
| Total Staff | 63 | 55 |
| **Average working Days Lost** | 3 | 5 |

[1]The total days lost for 2016-17, include absence that resulted in ill health retirement.

Sickness absence is managed in line with the CCG's policies and procedures 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 2017/18 the spend on Consultancy services (Note 6 of the Annual Accounts)is £12k, which includes £8k of VAT consultancy services (2016/17 £2k), £1k for an external review of Continuing Healthcare (CHC) processes and £6k for the CCG's share of costs from an external review of community hospitals, which was jointly commissioned with B&NES Council. This was offset by a (£3k) credit from prior year charges.

The CCG's external auditor, Grant Thornton, were paid £43k (including VAT) for Audit Services in the reporting year 2017/18 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 – audited

### Table 1: Off-payroll engagements longer than 6 months

For all off-payroll engagements as at 31 March 2018, for more than £245 per day and that last longer than six months:

| | Number |
|---|---|
| Number of existing engagements as at 31 March 2018 | 2 |
| *Of which, the number that have existed:* | |
| For less than one year at the time of reporting | 0 |
| For between one and two years at the time of reporting | 1 |
| for between 2 and 3 years at the time of reporting | 0 |
| for between 3 and 4 years at the time of reporting | 1 |
| for 4 or more years at the time of reporting | 0 |

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: New off-payroll engagements

For all new off-payroll engagements between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

| | Number |
|---|---|
| Total number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 | 0 |
| Of which…. | |
| Number assessed as caught by IR35 | 0 |
| Number assessed as NOT caught by IR35 | 0 |
| | |
| Number engaged directly (via PSC contracted to department) and are on departmental payroll | 0 |
| Number of engagements reassessed for consistency / assurance purposes during the year | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

**Table 3: Off-payroll engagements / senior official engagements**

For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 01 April 2017 and 31 March 2018.

| | |
|---|---|
| Number of off-payroll engagements of board member, and / or senior officers with significant financial responsibility, during the financial year. | 1 |
| Total number of individuals on payroll and off-payroll that have been deemed "board members, and / or, senior officials with significant financial responsibility", during the financial year. | 17 |

The one board member who was paid through off-payroll arrangements during 2017/18 was Helen Harris who was paid via her GP practice's payroll – Number 18 Surgery. Helen Harris resigned from the board with effect from 31st August 2017, so there are no longer any members of the CCG board who are paid via off-payroll arrangements.

The CCG has sought and received assurance from Number 18 Surgery that the appropriate deductions were for tax and national insurance contributions.

# Exit packages, including special (non-contractual) payments

## Table 1: Exit Packages

**Exit Packages agreed in the financial year**

| | 2017/18 | | | 2016/17 | | |
|---|---|---|---|---|---|---|
| | Compulsory redundancies number | Other agreed departures number | Total number | Compulsory redundancies number | Other agreed departures number | Total number |
| Less than £10,000 | 0 | 0 | 0 | 0 | 1 | 1 |
| £10,001 to £25,000 | 0 | 0 | 0 | 0 | 1 | 1 |
| £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** | **0** | **0** | **2** | **2** |
| **Total cost (£'000)** | **0** | **0** | **0** | **0** | **21** | **21** |

## Table 2: Analysis of Other Departures

| | 2017/18 | | 2016/17 | |
|---|---|---|---|---|
| | Other Agreed Departures | | Other Agreed Departures | |
| | Number | £'000 | Number | £'000 |
| Contractual payment in lieu of notice | 0 | 0 | 2 | 18 |
| Non-contractual payments requiring HM Treasury approval | 0 | 0 | 1 | 3 |
| **Total** | **0** | **0** | **3** | **21** |

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 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 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.

# Parliamentary Accountability and Audit Report

Bath and North East Somerset 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 at notes 1.15, 6 and 21. An audit certificate and report is also included in this Annual Report at pages 105 – 111.

# INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS BATH AND NORTH EAST SOMERSET CLINICAL COMMISSIONING GROUP

## Report on the Audit of the Financial Statements

### Opinion

We have audited the financial statements of NHS Bath & North East Somerset Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2018 which 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 notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

### Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the CCG in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit

evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

### Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG 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.

## Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

the Accountable Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the CCG's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

## Other information

The Accountable Officer is responsible for the other information. The other information comprises the information included in the Annual Report set out on pages 3 - 103, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the

course of our work including that gained through work in relation to the CCG's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

## Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Governance Statement does not comply with the guidance issued by the NHS Commissioning Board or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

### Opinion on other matters required by the Code of Audit Practice

In our opinion:

the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012; and

based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of

resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

### Opinion on regularity required by the Code of Audit Practice

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.

## Matters on which we are required to report by exception

### Under the Code of Audit Practice we are required to report to you if:

we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 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 made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

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

## Responsibilities of the Accountable Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accountable Officer's responsibilities pages 53 - 55, the Accountable Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the CCG lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the CCG.

The Accountable Officer is responsible for ensuring the regularity of expenditure and income in the financial statements.

The Audit Committee is Those Charged with Governance.

## Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

We are also responsible for giving an opinion on the regularity of expenditure and income in the financial statements in accordance with the Code of Audit Practice.

## Report on other legal and regulatory requirements – Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

### Matter on which we are required to report by exception - CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion 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 2018.

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

### Responsibilities of the Accountable Officer

As explained in the Governance Statement, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the CCG's resources.

### Auditor's responsibilities for the review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. 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.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves

whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the CCG has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

## Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of NHS Bath & North East Somerset Clinical Commissioning Group in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

***Peter Barber***

Peter Barber
Engagement Lead
for and on behalf of Grant Thornton UK LLP

2 Glass Wharf
Bristol
BS2 0EL

24th May 2018

# Annual Accounts

**Signed :**

**Tracey Cox**
**Accountable Officer**
**24 May 2018**

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**The Primary Statements:**



**Notes to the Accounts**

**Statement of Comprehensive Net Expenditure for the year ended 31 March 2018**

| | Note | 2017-18 £'000 | 2016-17 £'000 |
|---|---|---|---|
| Income from sale of goods and services | 3 | (482) | (1,064) |
| Other operating income | 3 | (760) | (537) |
| **Total operating income** | | **(1,241)** | **(1,601)** |
| Staff costs | 5 | 4,031 | 3,822 |
| Purchase of goods and services | 6 | 255,743 | 228,544 |
| Depreciation and impairment charges | 6 | 0 | 0 |
| Provision expense | 6 | (411) | 411 |
| Other Operating Expenditure[1] | 6 | 202 | 155 |
| **Total operating expenditure** | | **259,565** | **232,932** |
| **Net Operating Expenditure** | | **258,324** | **231,331** |
| Finance expense | 8 | 0 | 1 |
| **Net expenditure for the year** | | **258,325** | **231,332** |
| **Total Net Expenditure for the year** | | **258,325** | **231,332** |
| **Comprehensive Expenditure for the year ended 31 March 2018** | | **258,325** | **231,332** |

[1]Other operating expenditure consists of Chair and Non-executive costs (£148k), Clinical negligence costs (£4k) and Software development costs (£50k).
2016-17 prior year included Chair and Non-executive costs (£151k) and Clinical negligence costs (£4k).

The notes on pages 120 to 149 form part of this statement

**Statement of Financial Position as at 31 March 2018**

| | Note | **2017-18** £'000 | 2016-17 £'000 |
|---|---|---|---|
| **Non-current assets:** | | | |
| Property, plant and equipment | 10 | 20 | 0 |
| **Total non-current assets** | | 20 | 0 |
| **Current assets:** | | | |
| Trade and other receivables | 11 | 1,467 | 1,436 |
| Cash and cash equivalents | 12 | 78 | 169 |
| **Total current assets** | | **1,545** | 1,605 |
| **Total assets** | | **1,565** | 1,605 |
| **Current liabilities** | | | |
| Trade and other payables | 13 | (14,622) | (12,368) |
| **Provisions** | | 0 | (411) |
| **Total current liabilities** | | **(14,622)** | (12,778) |
| **Non-Current Assets plus/less Net Current Assets/Liabilities** | | **(13,057)** | (11,173) |
| **Total non-current liabilities** | | **0** | 0 |
| **Assets less Liabilities** | | **(13,057)** | (11,173) |
| **Financed by Taxpayers' Equity** | | | |
| General fund | | (13,057) | (11,173) |
| **Total taxpayers' equity:** | | **(13,057)** | (11,173) |

The notes on pages 120 to 149 form part of this statement

The financial statements on pages 106 to 111 were approved by the Governing Body on 24th May 2018 and signed on its behalf by:

Sarah James
Chief Financial Officer

**Statement of Changes In Taxpayers Equity for the year ended 31 March 2018**

| | General fund £'000 | Revaluation reserve £'000 | Other reserves £'000 | Total reserves £'000 |
|---|---|---|---|---|
| **Changes in taxpayers' equity for 2017-18** | | | | |
| **Balance at 01 April 2017** | **(11,173)** | 0 | 0 | **(11,173)** |
| **Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18** | | | | |
| Net operating expenditure for the financial year | (258,325) | 0 | 0 | (258,325) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | **(258,325)** | **0** | **0** | **(258,325)** |
| Net funding | 256,442 | 0 | 0 | 256,442 |
| **Balance at 31 March 2018** | **(13,057)** | **0** | **0** | **(13,057)** |

| | 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 costs for the financial year | (231,333) | | | (231,333) |
| **Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year** | **(231,333)** | **0** | **0** | **(231,333)** |

| | | | | |
|---|---|---|---|---|
| Net funding | 231,080 | 0 | 0 | 231,080 |
| **Balance at 31 March 2017** | **(11,173)** | **0** | **0** | **(11,173)** |

The notes on pages 120 to 149 form part of this statement

**NHS Bath and North East Somerset CCG - Annual Accounts 2017-18**

**Statement of Cash Flows for the year ended 31 March 2018**

| | Note | **2017-18 £'000** | 2016-17 £'000 |
|---|---|---|---|
| **Cash Flows from Operating Activities** | | | |
| Net operating expenditure for the financial year | | (258,325) | (231,333) |
| (Increase)/decrease in trade & other receivables | 11 | (31) | (580) |
| Increase/(decrease) in trade & other payables | 13 | 2,254 | 394 |
| Increase/(decrease) in provisions | 14 | (411) | 411 |
| **Net Cash Inflow (Outflow) from Operating Activities** | | **(256,513)** | (231,107) |
| **Cash Flows from Investing Activities** | | | |
| (Payments) for property, plant and equipment | | (20) | 0 |
| **Net Cash Inflow (Outflow) from Investing Activities** | | **(20)** | 0 |
| **Net Cash Inflow (Outflow) before Financing** | | **(256,533)** | (231,107) |
| **Cash Flows from Financing Activities** | | | |
| Parliamentary Funding Received | | 256,442 | 231,080 |
| **Net Cash Inflow (Outflow) from Financing Activities** | | **256,442** | **231,080** |
| **Net Increase (Decrease) in Cash & Cash Equivalents** | 12 | **(91)** | (28) |
| **Cash & Cash Equivalents at the Beginning of the Financial Year** | | **169** | 197 |
| 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** | | **78** | 169 |

The notes on pages 120 to 149 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 and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. 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.

### 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 or Section 10 of the Children Act 2004, the Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:

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

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

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

### 1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

periods if the revision affects both current and future periods.

1.4.1 Critical Judgements in Applying Accounting Policies
There are no critical judgements, apart from those involving estimations (see below) that management 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.

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 makes an assessment of prescribing expenditure for the year. Supporting information is subject to a time lag of 2 months which makes the value of the estimate for later months of the year potentially significant. This affects all CCGs.

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. The historic cost is used as a reasonable approximation of the fair value.
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. The historic cost is used as a reasonable approximation of the fair value.
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 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.8.2 Valuation

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

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

1.8.3 Subsequent Expenditure

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

1.9 Leases

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

1.9.1 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.

1.9.2 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.

1.10 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.

1.11 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 2.420% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

1.12 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution 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.

1.13 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 NHS Resolution 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.

1.14 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme the Clinical Commissioning Group contributed annually in 2014-15, 2015-16 and 2016-17 to a pooled fund, which is used to settle the claims.

1.15 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 2017-18 accounts.

1.16 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.

1.17 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 2017-18 accounts which have been recognised at historic cost.

1.18 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.

1.19 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.

1.20 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).

1.21 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'.

1.22 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'.

1.26 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'.

1.27 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.

1.28 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.

1.29 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The DHSC Group accounting manual does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to FREM adoption and early adoption is not therefore permitted.

- 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)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

"

The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year."

## 2 Financial performance targets

The NHS Clinical Commissioning Groups 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:

| | 2017-18 Target | 2017-18 Performance |
|---|---|---|
| Expenditure not to exceed income[1] | 261,063 | 259,585 |
| Capital resource use does not exceed the amount specified in Directions | 27 | 20 |
| Revenue resource use does not exceed the amount specified in Directions | 259,796 | 258,325 |
| Revenue administration resource use does not exceed the amount specified in Directions | 4,257 | 4,210 |

[1] Revenue Resource plus Capital Resource plus total operating income detailed in SOCNE

NHS England set the Clinical Commissioning Group a Revenue Resource Limit of £259,796,000 for 2017-18, and the Clinical Commissioning Group achieved an underspend of £1,471,000 against this target. This included the National risk reserve for the year of £1,140,000, £232,000 National Prescribing Rebate and £99,000 of local surplus. The Clinical Commissioning Group underspent by £47,000 on administration costs, against a target spend of no more than £4,257,000. We achieved a balanced financial position by the end of 2017/18. We met a further national requirement to hold 0.5% of our funding, as risk reserve, and released this into our position at the end of the year.

| | 2016-17 Target | 2016-17 Performance |
|---|---|---|
| Expenditure not to exceed income | 235,245 | 232,929 |
| Capital resource use does not exceed the amount specified in Directions | 0 | 0 |

| | | |
|---|---|---|
| Revenue resource use does not exceed the amount specified in Directions | 233,649 | 231,333 |
| Revenue administration resource use does not exceed the amount specified in Directions | 4,268 | 4,150 |

NHS England set 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 which included a release of national risk reserve of £2,234,000 into the position. The Clinical Commissioning Group also underspent by £118,000 on administration costs, against the target spend of no more than £4,268,000 in 2016-17.

**3 Other Operating Revenue**

| | **2017-18 Total £'000** | **2017-18 Admin £'000** | **2017-18 Programme £'000** | 2016-17 Total £'000 |
|---|---|---|---|---|
| Recoveries in respect of employee benefits | 563 | 347 | 216 | 425 |
| Education, training and research | 50 | 0 | 50 | 0 |
| Non-patient care services to other bodies[2] | 428 | 15 | 413 | 1,064 |
| Rental revenue from operating leases | 2 | 0 | 2 | 0 |
| Other revenue[1] | 197 | 0 | 197 | 112 |
| **Total other operating revenue** | **1,241** | **362** | **879** | **1,601** |

[1] Includes Home Office Grant Funding
[2]Reduction in 2017-18 is due to the consolidation of funding direct into a new contract.

**4 Revenue**

| | **2017-18 Total £'000** | **2017-18 Admin £'000** | **2017-18 Programme £'000** | 2016-17 Total £'000 |
|---|---|---|---|---|
| From rendering of services[1] | 1,241 | 362 | 879 | 1,601 |
| **Total** | **1,241** | **362** | **879** | **1,601** |

**[1] See above note[2] for 2017-18 reduction in revenue**

## 5. Employee benefits and staff numbers

### 5.1.1 Employee benefits 2017-18 Total

| | Total £'000 | Permanent Employees £'000 | Other £'000 |
|---|---|---|---|
| Employee Benefits | | | |
| Salaries and wages | 3,281 | 2,991 | 290 |
| Social security costs | 337 | 325 | 12 |
| Employer Contributions to NHS Pension scheme | 412 | 399 | 13 |
| Apprenticeship Levy | 1 | 1 | 0 |
| **Gross employee benefits expenditure** | **4,031** | **3,716** | **315** |
| Less recoveries in respect of employee benefits (note 5.1.2) | (562) | (480) | (82) |
| **Total - Net admin employee benefits including capitalised costs** | **3,469** | **3,236** | **233** |
| Less: Employee costs capitalised | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **3,469** | **3,236** | **233** |

### 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** | **2,950** | **448** |
| Less: Employee costs capitalised | 0 | 0 | 0 |
| **Net employee benefits excluding capitalised costs** | **3,398** | **2,950** | **448** |

**5.1.2 Recoveries in respect of employee benefits**

| | 2017-18 | | | 2016-17 |
|---|---|---|---|---|
| | **Total £'000** | **Permanent Employees £'000** | **Other £'000** | **Total £'000** |
| **Employee Benefits - Revenue** | | | | |
| Salaries and wages | (471) | (389) | (82) | (348) |
| Social security costs | (45) | (45) | 0 | (26) |
| Employer contributions to the NHS Pension Scheme | (46) | (46) | 0 | (33) |
| Termination benefits | 0 | 0 | 0 | (18) |
| **Total recoveries in respect of employee benefits** | **(562)** | **(480)** | **(82)** | **(425)** |

**5.2 Average number of people employed**

| | | | 2017-18 | 2016-17 |
|---|---|---|---|---|
| | **Total Number** | **Permanently employed Number** | **Other Number** | **Total Number** |
| **Total** | **68** | **64** | **4** | **65** |

There are no people engaged on capital projects in either 2016-17 or 2017-18

### 5.3 Exit packages agreed in the financial year

The Clinical Commissioning Group has not agreed any exit packages in 2017-18

| | 2017-18 Compulsory redundancies | | 2017-18 Other agreed departures | | 2017-18 Total | |
|---|---|---|---|---|---|---|
| | **Number** | **£** | **Number** | **£** | **Number** | **£** |
| Less than £10,000 | 0 | 0 | 1 | 0 | 1 | 0 |
| £10,001 to £25,000 | 0 | 0 | 1 | 0 | 1 | 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** | **0** | **2** | **0** | **2** | **0** |

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

**Analysis of Other Agreed Departures[1]**

| | 2017-18 | | 2016-17 | |
|---|---|---|---|---|
| | Other agreed departures | | Other agreed departures | |
| | Number | £ | Number | £ |
| Contractual payments in lieu of notice | 0 | 0 | 2 | 18,267 |
| Non-contractual payments requiring HMT approval* | 0 | 0 | 1 | 2,739 |
| **Total** | **0** | **0** | **3** | **21,006** |

[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. This does not include any special payments which are reported separately in the annual report. - £3k for 2016-17

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.

## 5.4 Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

### 5.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018 is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

### 5.4.2 Full actuarial (funding) valuation

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

For 2017-18, employers' contributions of £398,856 were payable to the NHS Pensions Scheme (2016-17: £357,628) were payable to the NHS Pension Scheme at the rate of 14.38% 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 NHS pension line of note 6.

**6. Operating expenses**

| | 2017-18 Total £'000 | 2017-18 Admin £'000 | 2017-18 Programme £'000 | 2016-17 Total £'000 |
|---|---|---|---|---|
| **Gross employee benefits** | | | | |
| Employee benefits excluding governing body members | 3,670 | 2,382 | 1,287 | 3,480 |
| Executive governing body members | 361 | 361 | 0 | 342 |
| **Total gross employee benefits** | **4,031** | **2,743** | **1,287** | **3,822** |
| **Other costs** | | | | |
| Services from other CCGs and NHS England | 1,548 | 1,095 | 453 | 1,706 |
| Services from foundation trusts | 105,168 | 0 | 105,168 | 101,100 |
| Services from other NHS trusts | 23,574 | 0 | 23,574 | 23,080 |
| Services from other WGA bodies | 184 | 0 | 184 | 143 |
| Purchase of healthcare from non-NHS bodies | 70,292 | 0 | 70,292 | 72,595 |
| Purchase of social care[1] | 102 | 0 | 102 | 0 |
| Chair and Non-Executive Members | 148 | 148 | 0 | 151 |
| Supplies and services – clinical[2] | 1,235 | 0 | 1,235 | 919 |
| Supplies and services – general | 494 | 80 | 414 | 426 |
| Consultancy services | 12 | 11 | 1 | 5 |
| Establishment[2] | 557 | 135 | 422 | 184 |
| Transport | 4 | 3 | 1 | 1 |
| Premises | 371 | 194 | 177 | 239 |
| Audit fees[3] | 43 | 43 | 0 | 54 |
| Prescribing costs | 24,880 | 0 | 24,880 | 25,436 |
| Pharmaceutical services | 12 | 0 | 12 | 0 |
| General ophthalmic services | 5 | 0 | 5 | 5 |
| GPMS/APMS and PCTMS[2] | 27,001 | 0 | 27,001 | 2,321 |
| Other professional fees excl. audit[4] | 70 | 48 | 22 | 58 |
| Legal fees | 15 | 15 | 0 | 0 |
| Clinical negligence | 4 | 4 | 0 | 4 |
| Research and development (excluding staff costs) | 50 | 0 | 50 | 0 |
| Education and training[2] | 178 | 53 | 125 | 70 |
| Provisions | (411) | 0 | (411) | 411 |
| CHC Risk Pool contributions | 0 | 0 | 0 | 202 |
| **Total other costs** | **255,536** | **1,829** | **253,707** | **229,110** |
| **Total operating expenses** | **259,567** | **4,572** | **254,994** | **232,932** |

[1] This spend relates to a scheme entered into with Social Care for the support of Clients with fractures. This is a new category of spend.
[2]The Clinical Commissioning Group took on greater responsibility for the delegated commissioning of Primary Medical Care on the 1st April 2017, this is reflected in the 2017-18 spend.
[3]In accordance with SI 2008 no.489, *The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008*, there is no limitation of auditor liability in respect of death or personal injury, fraud or fraudulent misrepresentation by it or its employees. In all other instances a total aggregate limit of £2m applies. The fee shown is inclusive of VAT, the net amount paid is £36k.
[4]Internal audit fees of £45k are included in this spend.

**7.1 Better Payment Practice Code**

| **Measure of compliance** | **2017-18 Number** | **2017-18 £'000** | 2016-17 **Number** | 2016-17 **£'000** |
|---|---|---|---|---|
| **Non-NHS Payables** | | | | |
| Total Non-NHS Trade invoices paid in the Year | 4,900 | 102,542 | 3,568 | 83,447 |
| Total Non-NHS Trade Invoices paid within target | 4,834 | 101,826 | 3,425 | 81,953 |
| **Percentage of Non-NHS Trade invoices paid within target** | **98.65%** | **99.30%** | **95.99%** | **98.21%** |
| **NHS Payables** | | | | |
| Total NHS Trade Invoices Paid in the Year | 2,845 | 129,786 | 2,569 | 125,993 |
| Total NHS Trade Invoices Paid within target | 2,824 | 129,760 | 2,466 | 124,815 |
| **Percentage of NHS Trade Invoices paid within target** | **99.26%** | **99.98%** | **95.99%** | **99.07%** |

**7.2 The Late Payment of Commercial Debts (Interest) Act 1998**

| | **2017-18 £'000** | 2016-17 £'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

| | 2017-18 £'000 | 2016-17 £'000 |
|---|---|---|
| **Interest** | | |
| Interest on late payment of commercial debt | 0 | 0 |
| Other interest expense | 0 | 1 |
| **Total interest** | **0** | **1** |
| **Total finance costs** | **0** | **1** |

## 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 2017-18 are disclosed below:

| **9.1.1 Payments recognised as an Expense** | | | **2017-18** | | | 2016-17 |
|---|---|---|---|---|---|---|
| | **Buildings £'000** | **Other £'000** | **Total £'000** | **Buildings £'000** | **Other £'000** | **Total £'000** |
| **Payments recognised as an expense** | | | | | | |
| Minimum lease payments[1] | 190 | 2 | **192** | 56 | 2 | **58** |
| Contingent rents | 0 | 0 | **0** | 0 | 0 | **0** |
| Sub-lease payments | 0 | 0 | **0** | 0 | 0 | **0** |
| **Total** | **190** | **2** | **192** | **56** | **2** | **58** |

[1]The 2016-17 expense contained credits for expenditure reducing the overall expense.

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

**9.1.2 Future minimum lease payments**

| | 2017-18 | | | | 2016-17 | | | |
|---|---|---|---|---|---|---|---|---|
| | **Land £'000** | **Buildings £'000** | **Other £'000** | **Total £'000** | **Land £'000** | **Buildings £'000** | **Other £'000** | **Total £'000** |
| **Payable:** | | | | | | | | |
| No later than one year | 0 | 0 | 1 | **1** | 0 | - | 1 | **1** |
| Between one and five years | 0 | 0 | 3 | **3** | 0 | - | - | **0** |
| After five years | 0 | 0 | 0 | **0** | 0 | - | - | **0** |
| **Total** | **0** | **0** | **4** | **4** | **0** | **0** | **1** | **1** |

**9.2 As lessor**

**9.2.1 Rental revenue**

| | **2017-18 £'000** | 2016-17 **£'000** |
|---|---|---|
| **Recognised as income** | | |
| Rent[1] | 2 | 0 |
| Contingent rents | 0 | 0 |
| **Total** | **2** | **0** |

[1]Rent contribution from STP arrangements.

**9.2.2 Future minimum rental value**

| | **2017-18 £'000** | 2016-17 **£'000** |
|---|---|---|
| **Receivable:** | | |
| No later than one year | 1 | 1 |
| Between one and five years | 3 | 0 |
| After five years | 0 | 0 |
| **Total** | **4** | **1** |

## 10 Property, plant and equipment

| 2017-18 | Information technology £'000 | Total £'000 |
|---|---|---|
| **Cost or valuation at 01 April 2017** | 0 | 0 |
| Additions purchased | 20 | 20 |
| **Cost/Valuation at 31 March 2018** | **20** | **20** |
| **Depreciation 01 April 2017** | 0 | 0 |
| **Depreciation at 31 March 2018** | **0** | **0** |
| **Net Book Value at 31 March 2018** | **20** | **20** |
| Purchased | 20 | 20 |
| **Total at 31 March 2018** | **20** | **20** |
| **Asset financing:** | | |
| Owned | 20 | 20 |
| **Total at 31 March 2018** | **20** | **20** |

### 10.1 Economic lives

| | Minimum Life (years) | Maximum Life (Years) |
|---|---|---|
| Information technology | 5 | 5 |

| **11 Trade and other receivables[1]** | **Current 2017-18 £'000** | **Non-current 2017-18 £'000** | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| NHS receivables: Revenue | 98 | 0 | 223 | 0 |
| NHS prepayments[2] | 548 | 0 | 775 | 0 |
| NHS accrued income | 22 | 0 | 0 | 0 |
| Non-NHS and Other WGA receivables: Revenue | 67 | 0 | 254 | 0 |
| Non-NHS and Other WGA prepayments | 465 | 0 | 194 | 0 |
| Non-NHS and Other WGA accrued income | 80 | 0 | 109 | 0 |
| Provision for the impairment of receivables | 0 | 0 | (145) | 0 |
| VAT | 28 | 0 | 26 | 0 |
| Other receivables and accruals | 159 | 0 | 0 | 0 |
| **Total Trade & other receivables** | **1,467** | **0** | **1,436** | **0** |
| **Total current and non-current** | **1,467** | | **1,436** | |

Included above:
[1]There are no prepaid pensions contributions in the receivables figures.
[2] £466k of the prepayments relate to Maternity payments made to the Royal United Hospitals under the pathway tariff introduced from 1st April 2016.

| **11.1 Receivables past their due date but not impaired[1]** | **2017-18 £'000 DH Group Bodies** | **2017-18 £'000 Non DH Group Bodies** | 2016-17 £'000 All receivables prior years |
|---|---|---|---|
| By up to three months | 86 | 22 | 218 |
| By three to six months | 9 | 0 | 70 |
| By more than six months[2] | 135 | 0 | 13 |
| **Total** | **230** | **22** | **301** |

[1]The Clinical Commissioning Group does not hold any collateral against outstanding receivables at 31 March 2018

[2] This sum has been resolved post the statement of financial position date. The Clinical Commissioning Group continues to pursue the debts and remains confident of their recovery.

| **11.2 Provision for impairment of receivables** | **2017-18 £'000 DH Group Bodies** | **2017-18 £'000 Non DH Group Bodies** | 2016-17 £'000 All receivables prior years |
|---|---|---|---|
| **Balance at 01 April 2017** | (145) | 0 | 0 |
| Amounts written off during the year | 87 | 0 | 0 |
| Amounts recovered during the year | 58 | 0 | 0 |
| (Increase) decrease in receivables impaired | 0 | 0 | (145) |
| Transfer (to) from other public sector body | 0 | 0 | 0 |
| **Balance at 31 March 2018** | **0** | **0** | **(145)** |

**12 Cash and cash equivalents**

| | **2017-18** | 2016-17 |
|---|---|---|
| | **£'000** | £'000 |
| **Balance at 01 April 2017** | 169 | 197 |
| Net change in year | (91) | (28) |
| **Balance at 31 March 2018** | **78** | **169** |
| | | |
| Made up of: | | |
| Cash with the Government Banking Service | 78 | 169 |
| **Cash and cash equivalents as in statement of financial position** | **78** | **169** |
| | | |
| **Balance at 31 March 2018** | **78** | **169** |

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

| 13 Trade and other payables | Current 2017-18 £'000 | Non-current 2017-18 £'000 | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| NHS payables: revenue | 1,788 | 0 | 1,611 | 0 |
| NHS accruals | 2,741 | 0 | 2,071 | 0 |
| NHS deferred income | 15 | 0 | 14 | 0 |
| Non-NHS and Other WGA payables: Revenue | 1,418 | 0 | 979 | 0 |
| Non-NHS and Other WGA accruals | 6,407 | 0 | 7,383 | 0 |
| Social security costs | 51 | 0 | 43 | 0 |
| Tax | 43 | 0 | 39 | 0 |
| Other payables and accruals[1] | 2,158 | 0 | 228 | 0 |
| **Total Trade & Other Payables** | **14,622** | **0** | **12,368** | **0** |
| Total current and non-current | **14,622** | | **12,368** | |

[1]Other payables include £62k outstanding pension contributions at 31 March 2018. The Clinical Commissioning Group took on greater responsibility for the delegated commissioning of Primary Care on the 1st April 2017. This is reflected in the 2017-18 spend.

## 14 Provisions

| | Current 2017-18 £'000 | Non-current 2017-18 £'000 | Current 2016-17 £'000 | Non-current 2016-17 £'000 |
|---|---|---|---|---|
| Continuing care | 0 | 0 | 411 | 0 |
| **Total** | **0** | **0** | **411** | **0** |
| **Total current and non-current** | **0** | | **411** | |

| | Continuing Care £'000 | Total £'000 |
|---|---|---|
| **Balance at 01 April 2017** | **411** | **411** |
| Arising during the year | 0 | 0 |
| Utilised during the year | 0 | 0 |
| Reversed unused[1] | (411) | (411) |
| Unwinding of discount | 0 | 0 |
| Change in discount rate | 0 | 0 |
| Transfer (to) from other public sector body | 0 | 0 |
| Transfer (to) from other public sector body under absorption | 0 | 0 |
| **Balance at 31 March 2018** | **0** | **0** |

[1] The provision for Continuing Care was based on estimated claims and average activity for the preceding 3 years. Anticipated activity reductions led to the release of this provision.

## 15 Other financial commitments

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

## 16 Financial instruments

### 16.1 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.

#### 16.1.1 Currency risk

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

#### 16.1.2 Interest rate risk

The Clinical Commissioning Group has undertaken minimal capital expenditure but this is not from borrowed sources and therefore it has no exposure to interest rate risk.

#### 16.1.3 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 (Note 11).

#### 16.1.3 Liquidity risk

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

## 16 Financial instruments cont'd

### 16.2 Financial assets

| | Receivables 2017-18 £'000 | Total 2017-18 £'000 |
|---|---|---|
| Receivables: | | |
| · NHS | 120 | 120 |
| · Non-NHS | 147 | 147 |
| Cash at bank and in hand[1] | 78 | 78 |
| Other financial assets[2] | 159 | 159 |
| **Total at 31 March 2018** | **504** | **504** |

[1]See note 12

[2]See note 11 other receivables

| | Receivables 2016-17 £'000 | Total 2016-17 £'000 |
|---|---|---|
| Receivables: | | |
| · NHS | 223 | 223 |
| · Non-NHS | 363 | 363 |
| Cash at bank and in hand | 169 | 169 |
| Other financial assets | 0 | 0 |
| **Total at 31 March 2017** | **756** | **756** |

### 16.3 Financial liabilities

| | Other 2017-18 £'000 | Total 2017-18 £'000 |
|---|---|---|
| Payables: | | |
| · NHS | 4,529 | 4,529 |
| · Non-NHS | 9,983 | 9,983 |
| **Total at 31 March 2018** | **14,512** | **14,512** |

| | 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** |

## 17 Operating segments

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

## 18 Pooled budgets

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

The pools are jointly controlled[1] and hosted by Bath and North East Somerset Council, this is the same arrangement as 2016/17.

[1]See note 1.3

Funds are pooled under Section 75 of the NHS Act 2006 for Adult Learning Disability, Better Care Fund, Mental Health 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 these Pooled Budgets are appended below:

| | **Total** | Better Care Fund | Adult Learning Disability | Mental Health | Children and Young People with Multiple and Complex Needs | Community Equipment |
|---|---|---|---|---|---|---|
| | **£000** | £000 | £000 | £000 | £000 | £000 |
| **Gross Funding** | | | | | | |
| Bath & North East Somerset Council | **48,269** | 21,169 | 20,496 | 3,885 | 2,516 | 203 |
| Bath & North East Somerset Clinical Commissioning Group | **46,005** | 35,887 | 6,139 | 3,114 | 392 | 473 |
| Income from client contributions | **1,796** | 0 | 1,796 | | 0 | 0 |
| Grant Funding | **4,643** | 4,562 | | | 0 | 81 |
| **Total Funding** | **100,713** | 61,618 | 28,431 | 6,999 | 2,908 | 757 |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Net overspend funded as detailed below** | | | | | | |
| Bath & North East Somerset Council | **2,298** | 0 | 1,148 | 661 | 489 | 0 |
| Bath & North East Somerset Clinical Commissioning Group | **500** | 0 | 350 | 73 | 77 | 0 |
| **Total Overspend** | **2,798** | 0 | 1,498 | 734 | 566 | 0 |

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs was signed on 12 April 2018 and all the other accounts were signed on 23 April 2018 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 or Section 10 of the Children Act 2004.

The NHS clinical commissioning group share of the expenditure, including the net overspends detailed above, handled by the pooled budget in the financial year were:

| | **2017-18** | 2016-17 |
|---|---|---|
| | **£'000** | £'000 |
| Income | 0 | 0 |
| Expenditure | 46,505 | 43,665 |

**19 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[1] | Dr Ruth Grabham | 873 | 0 | 79 | 0 |
| St Chad's Surgery[1] | Dr Elizabeth Hersch | 2,041 | 0 | 117 | 0 |
| St James Surgery[1] | Dr Ian Orpen | 1,307 | 0 | 67 | 0 |
| Chew Medical Practice[1] | Dr Timothy Sephton | 2,576 | 0 | 171 | 0 |
| Wiltshire CCG | Suzannah Power[2] & Tracey Cox[3] | 27 | (26) | 4 | (22) |

[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 and include payments made under delegated commissioning which was in place from 1st April 2017.
[2]Suzannah Power has a family member who is a GP representative for Wiltshire CCG.
[3] Tracey Cox was partially seconded to Wiltshire CCG since September 2016, this secondment ended 31st May 2017.

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 Resolution

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.

**20 Events after the end of the reporting period**

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

**21 Losses and special payments**

The Clinical Commissioning Group has no losses and special payments cases to report in 2017-18.