NHS
Bath and
North East Somerset
Clinical Commissioning Group

Annual Report and Accounts 2018/19

Contents

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PERFORMANCE REPORT

Tracey Cox
Chief Executive Officer
23 May 2019

Performance Overview

Chief Executive Officer and Clinical Chair Foreword

Welcome to our annual report for 2018/19 which provides a detailed overview of our performance during the year and highlights some of the key improvements we have made to improve health and wellbeing outcomes for the people of Bath and North East Somerset (B&NES).

In 2018/19 we made real progress to develop and build collaborative partnerships both in B&NES and across the wider system with partner organisations in Swindon and Wiltshire. Locally for example, we advanced our joint commissioning arrangements with B&NES Council as part of an integration programme. In October 2018 we agreed with Swindon and Wiltshire CCGs to move to a single joint management structure. As part of this process, we have had an appointment process for a new Chief Executive across the 3 CCGs and BSW (BaNES, Swindon and Wiltshire) Sustainability and Transformation Partnership (STP). Tracey Cox took up this post on March 1st 2019.

Collaboration means we can provide better and more joined up care for people and that helps everyone live healthier lives and stay out of hospital when they do not need to be there. Collaboration between our partners has resulted in a number of achievements this past year including:

- A coordinated and cooperative approach to the winter pressures across the health system
- Expansion of Home First that helps people to return safely home, earlier from hospital
- Launch of a trusted assessor scheme to reduce delays when people are ready for discharge from hospital
- Development of community teams to support frail or older people to maintain their independence
- Expansion of Adult Improving Access to Psychological Therapies (IAPT) for people with a long term condition.

We are also proud of the work of staff to improve the quality of services. This includes roll out of the National Early Warning Score (NEWS). We have been able to improve patient outcomes and experience by introducing a new digital system in our care homes that helps identify and monitor residents with deteriorating health.

Engagement with the public and patients is very important to us and your feedback really can make a difference. During 2018/19 for example, we completed a community mental health services review in collaboration with the council. The feedback we received has informed our new model of care and will be used to help shape future service developments.

Our primary care services in B&NES are of a high standard and last year 91 per cent of patients rated their experience of GP care as good. But our GPs and primary care teams are also under great pressure. They have started to work closer together in order to extend the range of services they can offer and to support each other to be sustainable. In 2018/19 we extended the early home visiting service so that a patient who is unwell and cannot get to the surgery, can call to request an early home visit. Working with practices and B&NES Enhanced Medical Services (BEMS) we also launched 'improving access' making it possible for hundreds of people to see a GP or nurse practitioner in the evenings or at weekends.

Meeting constitutional targets has been challenging this past year and we would like to thank staff across the system, who have worked exceptionally hard to ensure everyone continues to receive the best possible care.

We would also like to take this opportunity to thank John Holden for his invaluable input and contribution to our work. John was our Lay Member for Audit and Assurance and Vice Chair of the CCG for 6 years, since the CCG's inception. He also held the role of 'Conflicts of Interest' Guardian up until his retirement in March.

2018/19 was a special year in which we celebrated the 70th anniversary of the NHS and looked back at the achievements of people who work for our health service. In January 2019 the NHS Long Term Plan was published, setting out key ambitions for the service over the next ten years. Now we need to look forward and take the necessary steps to strengthen collaborative working and make sure our services are sustainable in the longer-term.

As ever, many of the achievements of the NHS would not be possible without our staff. We would like to thank all of our staff for their on-going support, hard work and dedication in enabling on-going service improvements to health and care services across B&NES.

If you have any feedback about our annual report, please do get in touch using the contact details on page 2.

Tracey and Ian

Tracey Cox

Chief Executive Officer for BaNES, Swindon and Wiltshire CCGs and STP

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 a membership organisation, made up of local GPs and practice staff from all 24 practices in Bath and North East Somerset (B&NES). Our geographical boundary matches that of Bath and North East Somerset Council. The number of patients registered with GP practices in B&NES is higher than the resident population, at 211,454 patients (February 2019) compared to 188,678 residents (2017 figures). In 2018/19 our budget was £275 million.

The range of services we oversee and commission is broad and includes primary care, 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, implement quality improvement projects and respond to seasonal pressures on hospital services.

We work collaboratively both with partner organisations in B&NES and across Swindon and Wiltshire as part of the Sustainability and Transformation Partnership (STP). During 2018/19, we collaborated with the Local Authority's commissioning teams to make changes to our governance processes and team structures that will enable us to work together in a more integrated way. This year we have also begun to work more closely with Swindon and Wiltshire CCGs and all three organisations are now led by a single Chief Executive, Tracey Cox (from 1 March 2019).

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

This year we have worked closely with the council to develop shared priorities and values that describe the way we want to work for the benefit of local people.

Both the council and the CCG must respond to the rising demand for our services, whilst making further savings every year. The following priorities help us decide how to use our limited resources most effectively:

1. Protecting and caring for our most vulnerable
2. Nurturing our local population's health, safety and wellbeing
3. Providing ways for everyone in the community to reach their full potential.

We have also adopted a set of shared values that describe the way we want to work with each other. These are the behaviours that everyone can expect from us:

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 188,678 residents in B&NES and we commission care on behalf of 211,454 people. There is a significantly higher proportion of residents aged 20-24 years than nationally, which can be attributed to the high student population.

Population density varies across areas locally, ranging from 74 people per square kilometre in Farmborough ward, to more than 8,100 for Westmoreland 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. The B&NES local housing strategy is expected to create an additional 13,000 homes by 2029 and will increase the local population by 16 per cent.

Population projections suggest that there will be large increases in the number of older people in B&NES. For example, by 2029 the number of over 75s in the population is projected to increase by 36 per cent (approximately 6,000 people) compared with 2016, and the number of over 90s is projected to increase from 2,000 to 2,500.

These changes have steadily increased demand on health and care services, which is mirrored at a national as well as a local level.

In 2018/19 there were:

- 350,000 face-to-face appointments with GPs
- 236,000 telephone contacts between GPs and patients
- 8,046 ambulance journeys
- 19,520 inpatient emergency attendance for non-elective admissions
- 39,107 emergency A&E attendances
- 17,443 elective day case admissions and 3,001 ordinary elective admissions
- 156,862 outpatient attendances
- 9,200 Urgent Treatment Centre attendances
- 9,926 Minor Injury Unit attendances.

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 (8.1 years earlier for men and 3.8 years for women).

Although people living in B&NES 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 three and a half times that compared with those in the least deprived parts of the area. We also know that one in four adults experience a diagnosable mental health problem in any given year and B&NES admission rates for self-harm are significantly worse than the England average.

Key issues and risks

Our Operational Plan for 2018-19 identified the key risks during this period as:

Maintaining Financial Stability and delivery of financial targets

During 2018/19 we continued to face a significant financial challenge, with the entire

workforce of the CCG working together to focus on achieving financial balance and ensuring value for money. We have built on the unprecedented financial achievement of 2017/18 to deliver our planned outturn position for the year. This position is a £39k operational surplus. We also achieved 90% of our full year savings target for the year and all financial targets and met all business rules for 2018/19.

The scale of financial challenge remains however, with increased funding outstripped by continuing demand and cost rises. We face a further year with a savings requirement of £6.2m to maintain financial stability, of which £1.7m is not yet supported by identified plans.

2019/20 is expected to be a foundation year for delivery of the NHS Long Term Plan. We will continue to build on developments during 2018/19 in joint working with B&NES Council and with Swindon and Wiltshire CCGs to ensure we deliver our commissioning responsibilities cost effectively and within our running cost funding. These relationships, and increasing wider working with BaNES, Swindon and Wiltshire system partners, will also support effective investment in plans to improve service quality whilst securing financial sustainability.

Mobilising and generating capacity to deliver Improving Value programmes at pace

Our Quality, Innovation, Productivity and Prevention (QIPP) programme delivered savings of £5.6m this year. You can read more about our QIPP programme on page 25.

The savings delivered included: schemes to improve the effective use of medicines and reduce avoidable waste; health optimisation; patient initiated follow ups (PIFUs); community frailty; hospice at home; continuation and extension of falls rapid response service; new integrated urgent care; urgent treatment centre contracts.

Recovering A&E 4 hour Performance and Referral to Treatment Access Times

We have struggled to meet some of the NHS constitutional targets in 2018/19 including the A&E four-hour waiting time target at our main provider, the Royal United Hospital (RUH). We continue to work with all of our providers to resolve the issues that are impacting on the whole health and care system's ability to deliver these national standards. We also work 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. We have constantly managed and aimed to improve the quality of health and care services to provide a good patient experience and services that are delivered safely and effectively. We have done this in the context of working within our financial allocation and managing the ever-increasing demand for services.

Contributing to the delivery of the STP programmes

We continue to work collaboratively with partners in BaNES, Wiltshire and Swindon (BSW) to transform and improve services for patients. In the last year we have contributed to the maternity transformation plan with a joint public consultation. We have jointly

commissioned an Integrated Urgent Care service that incorporates NHS111, a clinical assessment service and GP out of hours service which commenced in 2018/19. We have also established the BSW Mental Health Transformation Board and begun to develop one mental health strategy for BSW.

Collaboration across our health and care system

We are building closer ties with all our partner organisations and working towards being an integrated care system to provide our local population with the best quality care and health outcomes. We have established an Integrated Care Alliance in BaNES which brings together colleagues from the Royal United Hospitals Foundation Trust, Virgin Care; primary care, the council; voluntary sector and Healthwatch.

Sustainability and Transformation Partnership (STP)

Health and care organisations across B&NES, Swindon and Wiltshire (BSW) are working together to drive up the quality of services across our combined area, improve health outcomes and ensure our services are cost- effective and sustainable.

During 2018/19, there have been a number of collaborative projects across BSW STP. These include:

- A successful bid for £45m of new government funding which will help to expand services at Swindon's Great Western Hospital emergency department and contribute towards developing an integrated care centre in Trowbridge
- Development of a Maternity Transformation Plan and consultation on proposed changes to maternity services
- Establishment of the BSW Mental Health Transformation Board in order to develop a joint mental health strategy
- Creation of an alliance between the Great Western Hospital NHS Foundation Trust, Royal United Hospitals Bath NHS Foundation Trust, and Salisbury NHS Foundation Trust to help improve clinical services for those living in BSW
- Launch of the Integrated Urgent Care service, comprising NHS111, GP Out of Hours and the Clinical Hub.

In 2019/20, our STP's priorities are to:

- Improve the health and wellbeing of our population
- Develop sustainable communities and secondary care services
- Transform care across BSW, particularly focusing on outpatient experiences

- Create strong networks of health and care professionals to deliver the NHS Long Term Plan and BSW's operational plan.

Integrated Care Alliance

Senior leaders from local health and care organisations in B&NES are now working closer together to take collective responsibility for developing integrated care. Alongside the CCG, members of the Integrated Care Alliance (ICA) Board include: representatives from Avon and Wiltshire Mental Health Partnership NHS Trust (AWP); Bath and North East Somerset Council; The Royal United Hospitals NHS Trust (RUH); Virgin Care; Bath and North East Somerset Enhanced Medical Services (BEMS+); the voluntary sector; Healthwatch.

During 2018/19 the ICA Board was established with the aim of:

- Developing the relationships between Board members in a new environment and one which would be enabled through unified working with a common purpose;

- Strengthening place-based ways of working together across organisational boundaries, through choosing to focus on one particular area which was challenging for all partners to the Board and one which Board members felt was a priority;

- Testing the ICA Board could add value to place-based (B&NES) challenges and solutions.

The Board concluded that their focus area would be frailty in older people, recognising that there will also be other requirements for the ICA Board to consider, particularly in light of the NHS Long Term Plan such as the development of Primary Care Networks.

During 2019/20, the priorities for the ICA Board will include:

- Developing an operating model that considers the newly forming Primary Care Networks and determining how these can be shaped and influenced by the ICA Board;

- Developing the role of multi-disciplinary teams, with greater input from secondary care clinicians, so that frail, older people can be better supported;

- Considering how to build awareness and knowledge of the range of services ICA partners provide and supporting development of thriving, compassionate communities in which people are inspired and supported to look after themselves and each other;

- Considering current services, initiatives and projects, and determining any next steps, which might include prioritising areas for commissioning or service review or suggesting any realignment of investment;

- Developing a communications and engagement strategy so that our population and staff in constituent organisations understand the role of the Board in relation to place and the ICS arrangements across BSW.

How joined-up services benefits local people – a case study

One year old William has Treacher-Collins syndrome, a condition that affects the development of bones and other tissues of the face. By the time William had turned nine months old, he'd had five major operations: a tracheotomy, a gastrostomy, cleft palate repair surgery, and he had tracheal granulation tissue removed twice. His mum, Kate, told us how William's health and social care has worked for their family.

"We see 18 different professional groups of people. We have been really well supported; I've been so impressed by the way it's joined up. I feel that we've been really enabled to be the best we can be in this situation."

Integrating health and care with our local council

In 2018/19, we continued to develop our partnership with the council as part our Integrating Health and Care programme. By joining up the funding and expertise within our two organisations we can reduce duplication and use our combined resources more effectively to support the growing number of people in B&NES who are living with multiple, complex conditions.

A programme manager and a communications lead were recruited to deliver a programme

of structural and cultural change across both organisations. Between April and July 2018 a series of design groups, team discussions, drop-in sessions and interviews were held with staff to understand the opportunities and challenges.

Following this engagement exercise, a prioritised action plan was created called the Blueprint for Integrating Health and Care. The Blueprint sets out a phased programme of initiatives to be delivered in 2019 to improve integrated working between the two organisations based on our shared values, style, skills, staff, strategy, systems and structure.

In October 2018, staff were consulted on proposals for a structural reorganisation to bring NHS and council commissioners together in a single function for the first time. Following some amendments, the transition to the new structure began in January 2019 consisting of three directorates:

- Public Health and Prevention
- Community Transformation
- Complex & Specialist Services

In addition to the structural changes, a range of organisational development and IT projects have also been implemented. We have agreed a set of shared values and priorities with the council which will shape our day to day work and strategic decision-making over the coming year. We also held a series of joint staff briefings and leadership development sessions and identified four members of staff to be trained to deliver our *Coaching for Leaders* programme.

Underpinning our partnership with the council is the new Health and Care Board. The membership includes Cabinet members and officers from the council, alongside clinicians, managers and lay members from the CCG Board, who meet to make joint decisions about health and social care services.

Health and Wellbeing Board

The CCG's Clinical Chair, Dr Ian Orpen, co-chairs our local Health and Wellbeing Board alongside the 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. Tracey Cox, the Chief Executive of BaNES, Swindon and Wiltshire CCGs, is also represented on the Board and CCG staff members are active in its ongoing development and agenda management.[1]

In recognition of the wider determinants of health, the membership of the Board has been expanded beyond the local health and care community to include wider representation from public services, including representatives from Avon and Somerset Police, Avon Fire and Rescue Service, housing and the higher and further education sectors.

[1] Further information about our local Health and Wellbeing Board, including its Terms of Reference, our Joint Health and Wellbeing Strategy, and meeting documents can be found at https://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board1

During 2018/19, the Board have continued to help shape local services and promote good health and wellbeing. This includes a particular focus on assessing and building on the strengths and resources in our local communities to increase resilience and social capital, and develop better ways of delivering health outcomes. The Board have adopted a new Statement of Commitment to working in a more 'asset based' way moving forward. They are also working with the Third Sector Group to lend support to an emerging project called Compassionate Communities which seeks to build community resilience and support local people to be able to support themselves and others during times of need.

Alongside this, the Board has also lent its support to the developing "three conversations" model which aims to create a new relationship between health care professionals and people who need support. It draws on the individual's own resources and encourages professionals to forge stronger links with the wider community – in order to support people to make best use of all of the support available in their community.

The Board have also been building its relationship with the West of England Combined Authority (WECA), particularly as WECA develops its Local Industrial Strategy for the region. The Local Industrial Strategy is aimed at increasing productivity and providing an inclusive sustainable economy for it residents. The Board have stressed the connection between inclusive growth, employment, and the health and wellbeing of residents, and will be feeding in further as the Strategy develops.

Working together on prevention priorities (public health partnerships)

We work closely with the council's public health team to tackle health inequalities and promote healthy lifestyles. For example, we ran two 'postcard' campaigns with the public health team to raise awareness of the importance of the flu vaccine in specific at-risk groups. The first was targeted at pregnant women; after receiving feedback from midwives we created an information postcard which midwives gave to mums-to-be. Our second postcard campaign was a pilot scheme across B&NES where staff from three pharmacies put information in medication bags for those with long term respiratory conditions. The pharmacies were selected based on their alignment to practices with lower vaccination uptake rates. Early indications are that there has been an increase in vaccination uptake and a slight reduction in admissions for flu, but recognising that the flu season is still in progress at the time of writing.

We have also worked with the public health team to raise awareness of a number of campaigns including Stoptober, Dry January and Sugar Smart. On 1 January 2019 the RUH, St Martin's and Paulton Hospitals all became smoke free thanks to collaboration between public health and health and care partners across the STP. Members of the public, staff and visitors can no longer smoke anywhere on site, including the grounds and gardens or in vehicles and car parks.

The B&NES public health team have also been instrumental this year in supporting us to have discussions with our public involvement group, *Your Health, Your Voice,* on how we can reassure the public about any concerns they have regarding flu and MMR vaccines.

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 2018 we saw our scores improve in several key areas. For example, there is increased confidence in our system leadership role, with 77 per cent agreeing the CCG is very/fairly effective as a local system leader (up from 68 per cent in 2017) and 67 per cent of respondents confident the leadership will deliver improved outcomes (64 per cent in 2017). The survey also found that 63 per cent of all respondents have confidence in the CCG to monitor the quality of commissioned services (up from 50 per cent in 2017).

Amongst GPs there is increased confidence in our clinical leadership, up from 57 per cent in 2017 to 68 per cent in 2018. The survey included a new question for this year that highlights 86 per cent believe there is clear and visible clinical leadership at the CCG. Of those surveyed, 67 per cent of respondents said they felt they could influence our plans (up from 52 per cent in 2017).

Overall there is strong agreement that the CCG has effective working relationships with stakeholders. In particular 73 per cent of GPs and 80 per cent of voluntary sector respondents were satisfied. However, there are areas we need to address. 82 per cent of respondents said they know about our plans and priorities, but this is down from 98 per cent in 2017. There was also lower satisfaction with how effectively we communicate our plans and priorities (72 per cent, down from 84 per cent in 2017).

Although we rated highly for overall effectiveness of our working relationship with the voluntary sector, in other areas there was low/medium satisfaction with the CCG amongst this group of stakeholders. However the response rate for the voluntary sector was very low at 45 per cent.

We have used the survey results to inform our communications and engagement strategy for 2018/19. We have also begun a regular review of engagement processes with member practices and have increased the frequency of our primary care e-newsletter which we now publish weekly. You can read more about the results and our action plan here: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2018/06/Ipsos-MORI-survey-results-summary-report-2018-Final.pdf.

Our GP members

The CCG is clinically-led and our GP members continue to play a vital role in bringing their medical expertise to inform and help shape commissioning decisions. During 2018/19 local GPs have contributed to our Quality Innovation, Productivity Prevention (QIPP) savings schemes and other service improvements, while a group of GPs and nurses known as clinical integrators work with the CCG, practices and Virgin Care to develop community-based integration and multi-disciplinary team models. We have particularly worked with local GPs to shape referral pathways into acute and community services and develop appropriate mechanisms to better identify and support people who are frail or approaching the end of their life.

During 2018/19 our medical director has brought together secondary and primary care

clinicians with the aim of agreeing a new framework for clinical risk management. Two clinical risk summits were held during the year to gain a better mutual understanding of each partner's role and pressures and explore initiatives to support patient care during the winter. The first priority for 2019/20 is to develop a charter that underpins how our clinicians communicate and work together.

Our staff

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

How we engage with staff

We are committed to ensuring that our staff are given a voice and have the opportunity to provide feedback in an open environment. In addition to monthly staff briefings where staff are invited to ask questions about projects and updates, each year we conduct an anonymous staff survey to see what we are doing well and where we could support our staff further. Overall, the response from the survey for 2018/19 was positive; 91 per cent of staff believe that they have the skills and abilities to perform their role effectively, 72 per cent of respondents feel like they are able to make a positive improvement happen in their area of work, and 81 per cent receive the support they need from their line manager.

The survey showed us where we need to make improvements and we created an action plan to address these areas. As a result, we launched our 'Reclaim Your Lunch Break' campaign in January 2019 which highlights the importance of taking a break, introduced 'dress down Friday', and publicised the free counselling service and on site 'Mental Health First Aiders'. We are also identifying opportunities to celebrate our successes as an organisation, to help prepare ourselves for the challenges ahead.

Engaging people and communities

We are committed to putting people who use services, those who care for and support them, and the wider public, at the centre of everything we do, ensuring there is a public voice that can influence key decisions and help to shape our services. We believe that public participation helps us to understand people's needs and ensure that health and care services are better designed to meet these needs.

We involve local people in the work of the CCG in a range of ways, including holding regular meetings that people can attend and delivering outreach activities in the community to seek the views of different groups.

Regular meetings and roles

Your Health, Your Voice

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 and care 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 through to delivery.

Members are also encouraged to inform and support the CCG's engagement with the wider public, by advising us 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. Over the last year, members have shared their views on a number of topical issues including:

- How access to primary care can be improved and how we can raise awareness about the different professionals people can see: https://www.bathandnortheastsomersetccg.nhs.uk/documents/yourhealthyourvoice/your-health-your-voice-3-may-2018

- How the public feel about vaccines and how we can reassure them about any concerns they may have. Read summaries of these discussions: https://www.bathandnortheastsomersetccg.nhs.uk/documents/yourhealthyourvoice/your-health-your-voice-25-july-2018 and https://www.bathandnortheastsomersetccg.nhs.uk/documents/yourhealthyourvoice/your-health-your-voice-27-september-2018

- Changes to Advance Care Planning and how we can best support people earlier on to make plans for what they would want at the end of their life: https://www.bathandnortheastsomersetccg.nhs.uk/documents/yourhealthyourvoice/your-health-your-voice-27-september-2018

Members are also invited to lead sessions themselves. The findings of the group are formally reported to the CCG's public Board for review and discussion. Minutes from the meetings are available on our website.

Get involved

We are keen to recruit new members to the group in 2019 and will be targeting specific areas and communities who we need representation from.

If you would be interested in joining our Your Health, Your Voice group, or would like to find out more information, please email banes.yourvoice@nhs.net or call 01225 831861. Find out how you can get involved in all our current projects and consultations here: https://www.bathandnortheastsomersetccg.nhs.uk/get-involved

Other meetings people can attend

Members of the public are welcome to attend our Board Meetings in Public and can submit questions and read the agenda and papers on our website. We regularly invite people to share their personal experiences of health and care at the beginning of these meetings. They can also attend our Primary Care Commissioning Committee (PCCC) meetings. Our website informs the public about meetings they can attend:
https://www.bathandnortheastsomersetccg.nhs.uk/get-involved

Community Champions

Community Champions are volunteers who represent the public, people who use services and those who care for and support them. They are the voice of the community and share their experiences and ideas for developing new services.

In September-October 2018, a public representative who has a visual impairment and experience of using eye services helped us to decide who should deliver a new community eye service in B&NES. Their role involved evaluating and scoring bids from different services, and discussing these with colleagues from across the CCG as part of a moderation panel.

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.

Community Champions:

- Are **active members of working groups**. For example, as part of the community mental health services review, they have helped us to identify changes that need to be made and advise us on how we can engage effectively with a range of groups.

- **Advise commissioners on the development of services**. For example, they have been helping to shape a new model for delivering home care services in B&NES.

- Now receive a **newsletter** every three months, with updates on what is happening across transformation projects, and opportunities to get involved.

- Now **attend training days** as a group, where they are given opportunities to feedback on their role and develop skills, such as how to consult with others and capture their views.

The Champions helped us develop some top tips for consulting with the public:
https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2019/03/Consulting-with-the-public-top-tips.docx

Engagement projects in 2018-19

Community mental health services review (B&NES)

The CCG and council jointly led a review from the summer 2017 – March 2019 to look at the way community mental health services are delivered in B&NES, and to decide what improvements need to be made.

Further to initial engagement with people and professionals during the summer of 2017, we formed six working groups to look at everything people had told us so far and to develop a new model for how community mental health services could be delivered in the future. Each working group had membership from people across the council, CCG, Community Champions (who represent the public), service providers and voluntary sector representatives.

We held workshops in June 2018, inviting people who use services, those who care for and support them, those who deliver services, and the wider public, to come together to plan how we can improve how community mental health services are delivered. We delivered targeted face-to-face engagement with specific groups and communities, to ensure that a diverse range of views have informed the changes we are planning to make to services.

In summary, people told us they want us to:

- Focus on helping people, wherever possible, from reaching a point of crisis and having to get support at hospital
- Improve community-based support and ensure people get the right support, at the right time from specialist mental health services, particularly when they're experiencing crisis
- Make sure that services are more joined-up and work together better
- Make sure that more information is shared, and people are aware about what support is available
- Improve how people are connected from one service to another and ensure people don't fall through the gaps, as well as providing the right support for GPs and other healthcare professionals
- Have a 'Think Family' approach, with strong links between children and young people's and adult services
- Improve support for young people aged 16-25, including those moving from child to adult services.

We consulted with the public from 1 February – 22 February 2019 to get people's views on planned changes to community mental health services. We will share a summary report of this consultation in spring 2019. For more information about the consultation visit: https://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/mental-health-services-review

Transforming Maternity Services Together (B&NES, Swindon and Wiltshire)

B&NES, Swindon and Wiltshire Local Maternity System are proposing to make some changes to our maternity services, and we recently ran a public consultation (from November 2018 – February 2019) to ask people what they think of our proposal. More than 2,400 people took part in the consultation, including 1800 survey responses and 600+ face-to-face discussions.

We are now collating the feedback, which will be independently analysed, and the results will be used to help the Governing Bodies of BaNES, Swindon and Wiltshire CCGs make a final decision in the summer 2019. More information about the plans are available at: http://www.transformingmaternity.org.uk/

Community equipment services review

The council and CCG are reviewing how we can improve community equipment and minor adaptation services. Community equipment includes things like special mattresses, beds and cushions, hoists and slings, and walking frames. Minor adaptations include things like rails either inside or outside your home, and ramps.

From November 2018 – January 2019, we engaged with people who use community equipment and minor adaptation services, those who care for and support them, and people who prescribe or work with community equipment. We will share a summary of what people told us and what the next steps are on our website.

Reablement services review

The council and CCG are also reviewing the way reablement services are delivered, working with those who provide services to identify new ways of working and improvements that could be made. Reablement services provide personal care, help with

daily living activities and other practical tasks, usually for a short, fixed amount of weeks.

From December 2018 – February 2019, we held some detailed interviews with people who use/have used reablement services in B&NES, and those who care for and support them, to find out what they think about the services. We will share a summary of what people have told us on our website.

Home care services review

The Council and CCG are looking at how we provide home care services and how we can make them better. During the summer of 2018, we asked people to help us come up with a proposal for what services should look like in future. We then consulted with the public between December 2018 and January 2019 on our proposals to check we have got things right. The consultation document is available here: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2019/01/home_care_review_consultation_and_survey.pdf

There was strong support for our proposed approach with the majority of people (88%) agreeing that we had identified the right outcomes for a future service, that our proposal for how to deliver change was the right one, and that people are happy to try new ways of doing things. Where people asked for changes in wording regarding specific outcomes, we have now made these clearer. A business case is now being taken forward to allow us to go out to procurement with our agreed approach.

New community eye service

In June 2018, we asked people to tell us about their experiences of using eye services in B&NES, and what they thought of our plans to provide a community-based eye service, meaning that people could access appointments, treatment and support with their eye condition quickly and closer to home. People's views informed the development of the service model and a public representative helped us to choose the provider of this new service in October 2018.

You can find out what people told us here: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2019/03/Community-eye-service-engagement-summary.docx

Plans to develop our public involvement

In 2019-20, we are planning to further develop and improve our approach to public involvement, ensuring that people in B&NES shape and influence our commissioning activities.

This will include:

- Launching a newsletter to share opportunities for people to shape the development of health and care services.

- Continuing to reach out to a diverse range of community groups in B&NES, to ensure seldom heard people are fully represented in the CCG's decision making.

- Setting up a Citizens Panel to seek the views of different people across B&NES, Swindon and Wiltshire.

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 our plans and the changes we make to services.

During the community mental health services review (see above), we proactively sought the views of groups of people who we have struggled to engage with in the past, including students, young carers, the LGBTQ+ community, black and minority ethnic (BME) groups, and people living in deprivation.

When we consulted on our proposal to transform maternity services (see above), we made efforts to share and discuss the proposal with seldom heard groups, including parent carers, parents with learning disabilities and young parents (interviewed on our behalf by Curo staff).

During our engagement activities this year, we have had wide-ranging support from local groups and services who support and represent different communities, including Off the Record, the Carers' Centre, Bath Ethnic Minority Senior Citizens Association (BEMSCA), Curo, Your Say Advocacy, Southside Family Project, Creativity Works, Gay West, Deaf Plus, Vision Plus, University of Bath, Bath Spa University and Bath College**.**

Social media engagement

Our social media channels are an effective tool for engaging with a wide range of people and stakeholders. We share information about our local events and projects, national health campaigns, other services across B&NES.

Twitter
Between 1 April 2018 and 31 March 2019, we:

- Increased our followers from 1600 to 1935
- Sent over 1,400 tweets which made nearly 900,000 impressions
- Had over 1,500 link clicks, 1,600 retweets and 1400 likes
- Our most engaged with content included Easter and Christmas pharmacy opening hours across B&NES, our Transforming Maternity Services Together consultation, our Mental Health Service Review and the Stay Well this Winter campaign (organised nationally and includes information about flu vaccinations, norovirus etc.).

Facebook
Between 1 April 2018 and 31 March 2019, we:

- Increased our page likes from 160 to 289.

- Posted over 1,600 times, gaining a total reach of nearly 190,000 over the period.
- Had over 5,000 link clicks, 800 shares and 600 likes.

As we have a small organic following on Facebook, we have utilised paid advertising to reach more people with key information. For example, for the Transforming Maternity Services Together consultation, we spent £200 on promoting a post that encouraged members of the public to take part in the survey. This resulted in the post gaining over 26,000 impressions and 384 post clicks. For non-promoted posts about the consultation, the average impressions and clicks gained per post was 184 and 10 respectively. This shows how effective paid advertising is for increasing our reach through social media platforms.

We also use our social media platforms to share important, time critical updates. For example, on 1 February 2019, snow and subsequent road closures caused a number of our GP practices and providers to close or reduce their services. We created a 'live' webpage on our website which contained up-to-date opening information. We then promoted this webpage through our social media channels and encouraged key stakeholders across B&NES to share or retweet our content. On Twitter, our 7 updates gained 10,800 impressions, 38 retweets and 89 link clicks, indicating that the information we shared was valuable to our audience.

PERFORMANCE ANALYSIS

Tracey Cox
Chief Executive Officer
23 May 2019

Developing and delivery quality – QIPP initiatives

For 2018/19, to support our Quality, Innovation, Productivity and Prevention (QIPP) programme, we set up four work streams that develop and deliver quality, cost-saving initiatives. Each programme had a project team comprising staff from across the organisation, including clinical, analytical, financial, quality, administration, communication and public involvement specialists.

Below are the programmes from 2018/19 and some examples of the specific QIPP initiatives:

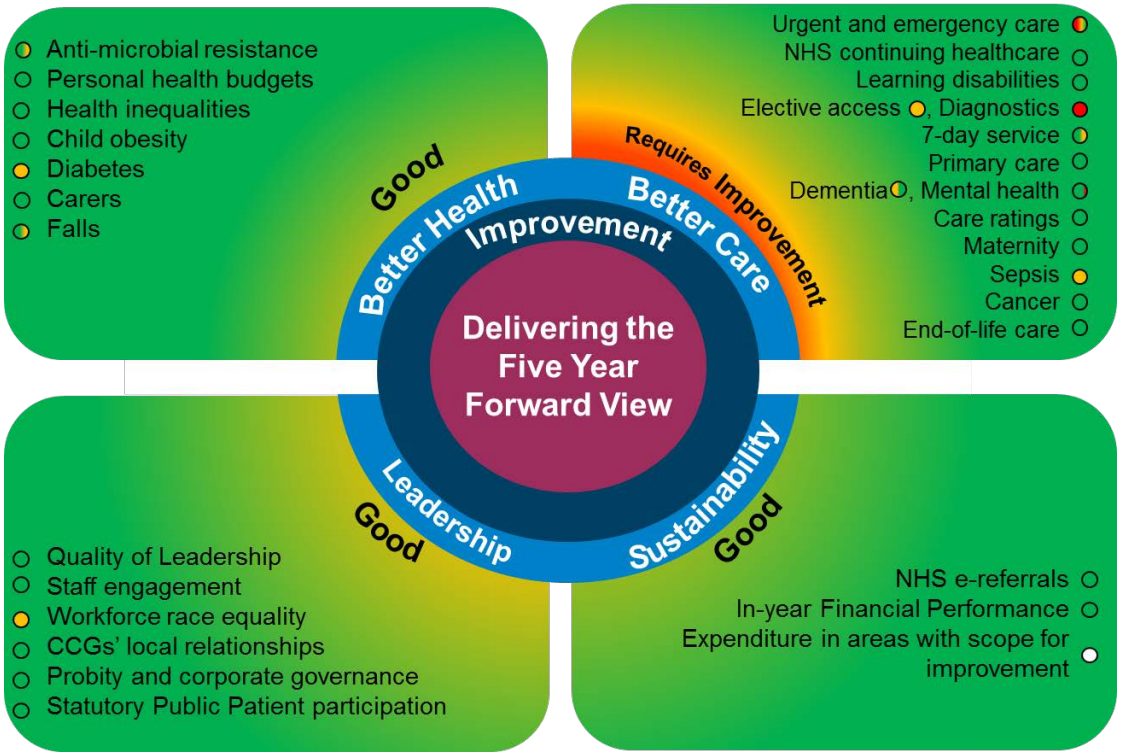
QIPP programme	**Examples of initiatives to generate savings**
Medicines optimisation	• Changes to our prescribing policy for medicines of low clinical value in line with NHS England guidance • Enhancements to the digital portals used by GPs to support their prescribing decisions • Reduction in medicines waste by working more closely with care home staff to review the prescribing needs of residents
Frailty and End of life / Continuing healthcare (CHC)	• Extending our Falls Response Service, which helps people up when they fall, refers them to community support and makes sure they don't fall again wherever possible • Extending our Early Home Visiting Service • A dedicated clinician experienced in frailty to implement a range of initiatives to develop understanding and better support people living with frailty
Elective demand management	• Extending our Health Optimisation project, which encourages people to get fit before surgery • Introducing Ardens, an online database where key documents are kept, which helps to ensure consistency of referrals for individuals and reduces GP's workload • Development of a community multi-disciplinary service to support those with chronic pain, and a clear route to other ways to manage pain if needed
Respiratory	• Increasing uptake of flu vaccinations in at-risk groups • Introducing early intervention screening for respiratory conditions, smoking cessation and harm reduction support • Establishing a regular IAPT Talking Therapies clinic so that those with Chronic Obstructive

	Pulmonary Disease (COPD) can be offered psychological support

How we measure our performance (IAF)

The CCG's annual assessment against national targets is monitored via the CCG improvement and assessment framework (IAF). Seven new measures have been included in the IAF in 2018/19 including: the Constitution Diagnostics waiting times standard; four mental health standards including the proportion of people on the severe mental illness (SMI) register receiving physical health checks; compliance with the £3/head commitment for investment in primary care transformation; and, expenditure in areas with scope identified for improvement.

We have self- assessed our performance[2], as shown in the table below, and this has been supported by the regional NHS England moderation process so far:



For the 'Better Care' domain, while our overall quality of care is rated good, NHS England automatically downgrades CCGs in areas where the national targets are repeatedly missed. Therefore, due to the diagnostics and A&E waiting time target performance at RUH, this element requires improvement.

[2] Based on a forecast using the latest available data at Q4.

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

Better Health

IAF Standard	Target (Nat avg)	Latest value	RAG*		Is B&NES in the top quartile? (Benchmarked with latest available data at Jan 19)
			Target	National	
Percentage of children aged 10-11 classified as overweight or obese	- (33.9%)	27.6% (2014-15 to 2016-17)	-		☑
Diabetes patients that have achieved all the NICE recommended treatment targets: three (HbA1c, cholesterol and blood pressure) for adults and one (HbA1c) for children	- (38.7%)	37.7% (2017-18)	-		
People with diabetes diagnosed less than a year who attend a structured education course	- (8.5%)	1.8% (2017-18 (2016 cohort))	-		
Injuries from falls in people aged 65 and over	- (2,051)	2,182 (18-19 Q3)	-		
Personal health budgets	- (59.9)	108.7 (18-19 Q3)	-		☑
Inequality in unplanned hospitalisation for chronic ambulatory care sensitive and urgent care sensitive conditions	- (2,109)	2,090 (18-19 Q1)	-		
Antimicrobial resistance: appropriate prescribing of antibiotics in primary care	0.965 (0.995)	0.821 (2018 11)			☑
Antimicrobial resistance: appropriate prescribing of broad spectrum antibiotics in primary care	10.0% (8.7%)	10.2% (2018 11)			
The proportion of carers with a long term condition who feel supported to manage their condition	- (0.59)	0.69 (2018)	-		☑

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

We are demonstrating good performance in the Better Health domain, with top-quartile performance returned for four of the nine measures.

While we perform well at only prescribing antibiotics where necessary, our rate is higher than the national average for delivering the national intention to reduce prescribing of antibiotics in the broad spectrum category. However, our 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. The latest rate is close to the target although we remain in the bottom quartile compared to other CCGs.

Better Care

IAF Standard	Target (National average)	Latest value	RAG		Is BaNES in the top quartile? (Benchmarked with latest available data at Jan 19)
			Target	National	
Provision of high quality care: hospital	- (-)	61 (18-19 Q3)	-		☐
Provision of high quality care: primary medical services	- (-)	68 (18-19 Q1)	-		☑
Provision of high quality care: adult social care	- (-)	62 (18-19 Q3)	-		☐
Cancers diagnosed at early stage	53.5% (52.6%)	58.4% (2016)			☑
People with urgent GP referral having first definitive treatment for cancer within 62 days of referral	85.0% (79.5%)	84.3% (18-19 Q3)			☑
One-year survival from all cancers	75.0% (72.8%)	74.6% (2016)			☑
Cancer patient experience	- (-)	8.8 (2017)	-	-	☐
Improving Access to Psychological Therapies – recovery	50.0% (51.8%)	51.1% (2018 11)		A	
Improving Access to Psychological Therapies – access	4.75% (4.2%)	4.8% (2019 02)			☑☐
People with first episode of psychosis starting treatment with a NICE-recommended package of care treated	53.0% (75.9%)	85.7% (2019 02)			☐

IAF Standard	Target (National average)	Latest value	RAG		Is BaNES in the top quartile? (Benchmarked with latest available data at Jan 19)
			Target	National	
within 2 weeks of referral					
Children and young people's mental health services transformation	(-)	Data unavailable	-	-	☐
Mental health out of area placements	- (123)	157 (18-19 Q3)	-		☐
Mental health crisis team provision	(-)	Data unavailable	-	-	☐
Proportion of people on GP severe mental illness register receiving physical health checks	50% (-)	19.5% (18-19 Q3)	-		☐
Cardio metabolic assessment in mental health environments	(-)	Data unavailable	-	-	☐
Delivery of the mental health investment standard	- (-)	2 (18-19 Q3)	-		☑
Ensuring the quality of mental health data submitted to NHS Digital is robust (DQMI)	(-)	0.8 (18-19 Q2)	-	G	☐
Reliance on specialist inpatient care for people with a learning disability and/or autism	- (-)	26 (18-19 Q3)	-		☑
Proportion of people with a learning disability on the GP register receiving an annual health check	- (51.4%)	43.4% (2017-18)	-		☐
Completeness of the GP learning disability register	- (0.49%)	0.50% (2017-18)	-		☐
Maternal smoking at delivery	- (10.5%)	6.7% (2018 12)	-		☑

IAF Standard	Target (National average)	Latest value	RAG		Is BaNES in the top quartile? (Benchmarked with latest available data at Jan 19)
			Target	National	
Neonatal mortality and stillbirths	- (-)	3.31 (2016)	-		☑
Women's experience of maternity services	- (82.7)	85.3 (2018)	-		
Choices in maternity services	- (60.4)	63.6 (2018)	-		☑
Estimated diagnosis rate for people with dementia	66.7% (67.9%)	62.9% (2019 01)			☐
Dementia care planning and post-diagnostic support	- (77.5%)	80.0% (2017-18)	-		☐
Emergency admissions for urgent care sensitive conditions	- (2,409)	2,153 (18-19 Q2)	-		☐
Percentage of patients admitted, transferred or discharged from A&E within 4 hours	95.0% (86.6%)	81.9% (2019 03)			☐
Delayed transfers of care per 100,000 population	- (10.3)	13.8 (2019 02)	-		☐
Population use of hospital beds following emergency admission	- (498.9)	446.3 (18-19 Q2)	-		☑
Percentage of deaths with three or more emergency admissions in last three months of life	- (5.4%)	4.6% (2017)	-		☑
Patient experience of GP services	- (83.8%)	90.8% (2018)	-		☑
Primary care access – proportion of population benefitting from extended access services	- (98.4%)	100.0% (2019 02)	-		☑
Primary care workforce	- (1.05)	1.21 (2018 03)	-		☐☑

IAF Standard	Target (National average)	Latest value	RAG		Is BaNES in the top quartile? (Benchmarked with latest available data at Jan 19)
			Target	National	
Count of the total investment in primary care transformation made by CCGs compared with the £3 head commitment made in the General Practice Forward View	- (-)	2 (18-19 Q3)	-		☑
Patients waiting 18 weeks or less from referral to hospital treatment	92.0% (87.0%)	89.7% (2019 03)			
Achievement of clinical standards in the delivery of 7 day services	- (-)	2 (2016-17)	-	-	☐
Percentage of NHS Continuing Healthcare full assessments taking place in an acute hospital setting	15.0% (9.2%)	0.0% (18-19 Q4)			☑
Evidence that sepsis awareness raising amongst healthcare professionals has been prioritised by the CCG	- (-)	2 (2019)	-		☐
Percentage of patients waiting 6 weeks or more for a diagnostic test	1.0% (2.3%)	4.51% (2019 03)			☐

*The national RAG rating considers performance against the national average (where available), our rank nationally, the quartile in which we are placed and what actions are in place to improve performance. Some measures are currently not published with benchmarking information, so are shown as unavailable.

Our performance in the Better Care domain is generally very good, with performance in the top quartile for 17 of 34 indicators for which benchmarking data is available. The areas of Cancer, Mental Health and Maternity continue to perform well, despite challenges in meeting targets in the former during some months of the year. While Q4 cancer results are awaited for people with urgent GP referral having first definitive treatment for cancer within 62 days of referral, the first two months of the quarter were on target although March is expected to be challenging.

Due to increasing demand across the health and social care system during 2018/19, B&NES' performance against the constitution standards for those attending A&E being admitted, transferred or discharged within 4 hours and the proportion of patients waiting six weeks or more for diagnostic tests is below expected levels. We are not alone in facing these performance challenges, as pressure in these areas is felt across the country. We continue to work with our providers to manage performance in these areas through forums such as the A&E Delivery Board and the Referral-To-Treatment Steering Group. In addition, a system-wide improvement plan is in place to support improvements in A&E and

the RUH has a recovery action plan for diagnostics performance. We also work 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.

Performance for the number of people treated within 18 weeks of a referral to a consultant-led service has improved in 2018. Although the 92 per cent standard has not been achieved, we are performing above the national average. The main planning requirement set by NHSE for 2018/19 was to reduce the waiting list to below the March 2018 level by March 2019. At the end of 2018/19, BaNES' waiting list was less than 1% above the March 2018 level. However, this is due largely to the addition of patients in Pain and Gastroenterology at RUH in 2018/19 which weren't recorded in 2017/18 due to the reopening of a service and a change in reporting processes respectively. If you exclude these changes, the waiting list fell compared to 2017/18.

For the new measure, the proportion of people on the GP severe mental illness register receiving physical health checks is below the targeted level. However, national benchmarking data is not currently available, so it is unclear whether performance is out-of-step with other CCGs. Further actions to help to deliver the target are being discussed between primary care and public health teams.

Progress against national priorities

Dementia

Although the dementia diagnosis rate has increased since 2017/18 and is now at 63.8%, achieving the 66.7% target remains challenging. The predicted rate of dementia varies across the country, and local intelligence suggests that levels in B&NES may be lower than the national calculation indicates. We are nonetheless committed to working towards the national target and we are taking steps to ensure that opportunities to diagnose patients are not missed, which is supported by the dementia action plan and work to share knowledge across BSW STP.

As part of the B&NES Dementia Action Plan, we have carried out an audit of two local nursing homes, which identified some patients without a diagnosis and these have now been followed up by their GP. Based on these findings, there may also be a number of undiagnosed patients in sheltered housing and domiciliary care and this is being explored by Virgin Care. We have a number of other schemes which include providing dementia friendly training to all GP practices, slow shopping and recruitment of a dementia support worker. As well as helping us make sure that those living with dementia are best supported, these schemes will also enable us to improve the diagnosis rate across B&NES.

Mental Health

Building on the priorities that were identified in the Your Care, Your Way review of community health and care services in 2015–17, we have been working with B&NES Council to look at the way community mental health services are delivered locally. As a result of the Mental Health Review (see engagement section above), we will be collaborating with health and care partners to deliver the new Thrive model of Mental

Health provision in B&NES in 19/20.

The Thrive model supports the provision of mental health services using a whole-system, population-based approach which focuses on the mental health and mental illness needs of different groups of people as well as the needs of individuals. It enables integration across the health, education, social care and voluntary sector, with a central focus on delivering improved outcomes for people. The implementation of the Thrive model will also allow for more effective links to place initiatives such as GP Primary Care Networks and will ensure mental health is embedded across all sectors of provision.

We have continued to meet the national requirements for increased investment in both Adults' and Children's mental health services.

End of Life (EoL) Care

The quality of end of life care depends on many factors within the wider health and social care system, including acute care, community services and palliative care.

The standard of end of life care for children and young patients in B&NES is excellent and we are committed to ensuring that this care continues to improve across all ages. As such, we are focusing on improving the care for individuals with specific care needs such as those with frailty, dementia and learning disabilities, and in 2018/19 we had dedicated work programmes for frailty and end of life care. This included continuing the work of a dedicated community frailty nurse, recruiting an advanced care planning nurse and strengthening the service from our local hospice team so they could provide additional 'hospice at home' care. Our ethos to support informed choice at end of life to facilitate planned care and quality of life continues to be embedded in our projects and work with providers.

Diabetes

We continue working on a number of projects to improve outcomes for people with diabetes in primary care following our successful bid for monies from the Diabetes Transformation Fund in partnership with the RUH. For example, we have a specialist diabetes pharmacist who works alongside practice staff to optimise medical therapy, and we have implemented a diabetes risk stratification tool which allows members of a GP practice diabetes team to take responsibility for different aspects of an individual's care.

Through the accredited X-PERT Diabetes programme, which is delivered by Virgin Care, we have provided structured education to those living with the disease. The Healthier You: NHS Diabetes Prevention Programme (NDPP), which identifies those at high risk and refers them onto a behaviour change programme which provides access to education on healthy eating and lifestyle, help with weight loss (for overweight participants), and bespoke physical exercise programmes, has a participation rate of over 90 per cent.

We have continued to standardise the organisation and delivery of diabetes management at GP practice level, which includes targeted interventions for under 70's, practice nurse and healthcare professional support, and ensuring robust evaluation of all initiatives. In addition, 32 multidisciplinary team 'virtual clinics' have been held this year that have helped 64 per cent of patients achieve their blood sugar levels target.

Cancer

In the CCG Cancer Improvement and Assessment Framework (2017/18), we were listed as one of 14 CCG's who were rated ***'outstanding'*** this year and last against the cancer indicators measured in the CCG IAF. Read the framework here: https://www.england.nhs.uk/wp-content/uploads/2018/08/ccg-cancer-assessment-2017-18-v1.pdf

Performance overall in 2018/19 (to the end of February) is better than the 85 per cent NHS Constitution target (85.3 per cent). However, there have been challenges in achieving the targets each month as pressure in Urology and Gastroenterology has affected performance, particularly in the summer and autumn. We are working with our partners to understand how additional funding in 2019/20 will help us improve performance.

We partnered with Public Health to support screening programmes and promote public health messages about reducing the risk of developing cancer, and as such, several hospital sites across the STP went completely smoke-free in 2018/19. To support improvements in early diagnosis, we worked with the Somerset Wiltshire Avon and Gloucester (SWAG) Cancer Alliance, providers and primary care to implement elements of the rapid assessment and diagnostic pathway for lung, prostate and colorectal cancer. This included the introduction of qFIT in primary care which is a recovery package that can greatly improve outcomes for people living with and beyond cancer. Together with the SWAG Cancer Alliance and other partners, we have begun to roll out a recovery package across B&NES, Swindon and Wiltshire as part of the two year cancer transformation programme.

Maternity care

We were delighted to be rated as outstanding for our maternity services by NHS England. The overall rating for maternity is based on four indicators which were chosen to align with a number of themes from Better Births, the report of the National Maternity Review:

- Stillbirth and neonatal mortality rate
- Women's experience of maternity services
- Choices in maternity services
- Rate of maternal smoking at delivery.

In 2018/19, the B&NES, Swindon and Wiltshire Local Maternity System ran a public consultation (from November 2018 – February 2019) about our proposal to transform maternity services across the area. For more information about the consultation, please visit page 20.

Urgent care

In 2018/19, we commissioned enhanced urgent care services and in doing so, changed two of our service providers for Urgent Care. The RUH partnered with BEMS to run the Urgent Treatment Centre based at the hospital, which offers urgent treatment around the clock to patients who cannot wait to be seen by their local GP or are not registered with a local practice. This includes "streaming" of patients arriving at the Emergency Department to provide advice and direction to ensure patients receive the right service to meet their needs. The jointly commissioned BaNES, Swindon and Wiltshire Integrated Urgent Care

Service, which includes NHS111, Clinical Assessment Services and GP Out of Hours service, was launched by Medvivo in May 2018. The service has since been hailed as the only truly integrated example currently in operation.

Throughout 2018/19 the local system failed to meet the A&E waiting time target (95 per cent of attendees to be seen within four hours). Nationally performance continues to be below the targeted level but the local system is performing below the national average. As a consequence, the RUH has been rated at Category 4 as a Trust, the lowest level possible. Factors affecting performance include increased attendances compared to 2017/18 and high numbers of ambulance conveyances.

We continue to implement a four hour improvement plan with the RUH and community providers across B&NES and Wiltshire. The plan consists of actions for both the RUH and community providers and includes a focus on reducing the numbers of patients who have been in hospital for more than 21 days. Progress against the plan is being monitored at fortnightly strategic forums and at A&E Delivery Board. Due to the recruitment of additional reablement support workers and the appointment of a Trusted Assessor to support the prompt discharge of those living in or transferring to Care Homes, the number of patients who stay in acute care for more than 21 days has reduced since 2017/18.

Targets for 2019/20

Looking ahead to 2019/20, NHS England has undertaken a review of the core set of NHS access standards. The review has recommended the testing of the new standards, including any thresholds that might accompany the standards. Alongside the testing, NHSE will undertake extensive engagement across the service ahead of presenting the evidence and making final recommendations to Government and full implementation beginning spring 2020.

Around a fifth of all emergency admissions from A&E happen in the final 10 minutes before the deadline, suggesting that hospitals are being driven to focus on the target, rather than what is the best approach for each patient. Instead of aiming to see and treat virtually all A&E patients in four hours, the sickest patients will be prioritised for quick treatment. NHS England wants to ensure that patients who come in to A&E with, for example, heart attacks, acute asthma, sepsis and stroke start their care within an hour. The changes will be piloted during 2019 and, if successful, could be introduced in 2020.

There would also be a move towards average waiting times for planned operations, such as knee and hip replacements. Cancer targets will be simplified so that there are two key targets for treatment starting on top of the incoming 28-day goal for diagnosis.
New targets will be introduced for mental health care with the goal of ensuring that everyone who needs urgent crisis care in the community receives it within 24 hours. Access to other community mental health services - for children and adults - will be expected in four weeks. This is the first time that these services will have had targets attached to them.

CCG priorities

Children and young people

During 2018/19 we extended a service which allows GPs to seek expert advice from a paediatrician during a child's medical examination. The service, which was set up by the RUH, also allows GPs to send emails and photos which detail symptoms so that a joint clinical decision can be made.

This service is supported by the digital paediatric HANDIApp, which is available for free via iTunes and Google Play. The app, which is aimed at both community health professionals and members of the public who care for young children, offers free support and expert advice on how to manage common childhood ailments.

Both of these service improvements have now been agreed to continue as business as usual following their successful trial.

The CCG continues to work with the council's children's services team to implement the Special Educational Needs and Disability (SEND) reforms. We have also further developed the local health offer for children and young people who are eligible for Education Health Care plans, and as part of this, the ASD Service is being reviewed and will be recommissioned by September 2019.

There have also been a number of improvements with Child and Adolescent Mental Health Services (CAMHS), supported by our increased investment in this area in line with national requirements:

- The children and young people's community Eating Disorder Service (TEDS) is expected to meet the 2020 national targets for referral-to-treatment times for children and young people with a suspected eating disorder

- Instead of having to first talk to a healthcare professional, children and their families can self-refer online to Oxford Health for general CAMHS referrals

- GPs can now send referrals to CAMHS via secure email

- Young people can access Kooth's online support and counselling, and CAMHS has additional funding to offer digital assessments and cognitive behaviour therapy for children and young people.

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.

The CCG and council have continued to work with Virgin Care to make sure that our future model for community services addresses the priorities that were proposed by people as part of our community services review Your Care, Your Way. This includes ensuring we have services that are easier to navigate, are person centred, and are joined-up so people only have to tell their story once.

During 2018/19 the community services provider introduced SEM scanners (predictors for pressure ulcer risk) at two community hospitals and rolled out mobile technology across its reablement and district nursing teams to help staff work more efficiently and improve patient experience. Virgin Care also supported a number of initiatives to help discharge

patients earlier from hospital including the expansion of Home First and reducing waiting times for social care assessments.

Virgin is also making progress with developing an integrated care record which will help reduce the amount of times a patient has to tell their story to different health and care professionals and is working to develop Care Navigators – a new role which will help people to navigate their way around health and care, helping them to get the most from local services.

In partnership with the council, we are re-commissioning our community equipment and minor adaption services from April 2020. We are also working with the Council to redesign home care and reablement services in B&NES to help more people live at home and remain as independent as possible. Read pages 20-21 for more information about these reviews.

Primary Care

We have 24 GP practices in our area that are all rated as 'good' or 'outstanding' by the Care Quality Commission. In the national GP patient survey, 98 per cent of our patients say they have confidence or trust in their GP and over 91 per cent describe their overall experience as 'good'.

Our two year Primary Care Strategy, launched in September 2018, outlines how we intend to support our practices and focuses on five main areas: access to care; models of care; workforce sustainability; workload; and estates and infrastructure. Read the strategy here: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2016/06/BANES-Primary-Care-Strategy-FINAL.pdf

In October 2018 we became 'fully delegated' commissioners of primary care, which means we are continuing to take on more responsibility for commissioning and quality assuring primary medical care from NHS England. This process offers us increased control of budgets so that we can protect and invest resources so they can be used most effectively.

In line with national guidance (NHS Long Term Plan), we have continued to invest in primary care and make plans to ensure the longer-term sustainability of our practices throughout 2018/19. This includes:

- Launching our Improving Access pilot scheme in October 2018. This scheme allows the local community to access evening and weekend appointments

- Working with practices in terms of resilience and collaboration. For example, we have supported digital developments so that GPs can work at different practice sites across B&NES, preparing and supporting them to work as Primary Care Networks

- Piloting the online consultation programme, a tool which enables individuals to interact digitally with their practice to improve access and make best use of clinician's time. We plan to roll this programme out further during 2019/20. We have also continued to work with our practices to update their websites to make them easier for individuals to navigate and to better support the Online Consultation programme. Going forward we will support the national roll out of the NHS App that

provides a simple and secure way to access a range of NHS services on a smartphone or tablet.

Learning Disabilities

Through 2018/19, we continued to encourage health and care partners to participate in the learning disability mortality review programme. We have a core team of independent reviewers from a variety of organisations, and completed reviews identify learning and best practice which is then disseminated to relevant organisations. The aim of these reviews is to drive up quality within health and social care service and reduce premature mortality for people with a learning disability.

We published our Market Position Statement, which sets out our commissioning intentions for the next two years and is based on the predicated volume and demand of the local care and support market. The Market Position Statement is a starting point for further consultation and partnership working with service providers and can be viewed here: https://www.bathnes.gov.uk/services/care-and-support-and-you/learning-disabilities/market-position-statement-adults-learning

In April 2018, we finalised and issued our new contract and service specification for services that support people with a learning disability and/or Autism in both a registered care setting and in community support services. The specification is outcomes-based and shifts the focus from tasks and processes to the impact on the people receiving support. It was developed in co-production with individuals who have a learning disability and who use a variety of support services.

We finalised two projects which were funded by the Department of Health's Housing and Technology Capital Fund. In partnership with Advance Housing, we have supported six people to buy their own home under HOLD (home ownership for people with long term disabilities), a Government-approved shared ownership model. All of the people using the scheme have complex needs and require specialist housing to help them to live as independently as possible. We have supported 34 people to gain access to assistive technology, which includes assistive, adaptive, and rehabilitative devices. These devices enable people to become more independent, to be less reliant on paid staff, and provide individuals with the opportunity to be more in control of their own home environment while maintaining personal safety.

Improving quality and reducing health inequalities

Patient Experience

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 an individual is dealt with compassionately, effectively and in a timely manner.

In 2018/19, we received a total of two complaints. 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. We monitor all feedback received directly by providers in contract monitoring meetings to identify themes and trends.

There have been 117 patient advice and liaison service (PALS) contacts received directly by the CCG.

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: https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/compliments-concerns-and-complaints-policy .

Safeguarding

Following the publication of national statutory guidance, we reviewed our partnership arrangements for safeguarding children and worked with the council and Avon and Somerset Police to design a new model for our safeguarding boards. Our aim is to reduce duplication and join up safeguarding activities so that we can continue to protect the health, wellbeing and human rights of everyone living in B&NES.

In partnership with Swindon and Wiltshire CCGs, we have developed a single set of performance measures so that we can be assured that all of the services we commission are effectively undertaking their safeguarding responsibilities.

We have developed the local Safeguarding Health Professional Network to align adult and child safeguarding more effectively and share good practice to learn from each other. We are also working across the health sector and with our multi-agency partners to share information with relates to children, young people and adults who are at risk of exploitation.

We have participated in three serious adult reviews which have now been published. These reviews all relate to self-neglect and the learnings from these have resulted in us updating a self-neglect policy so that it better supports health professionals working with adults at risk. The policy also requires all organisations to nominate a self-neglect champion who is responsible for ensuring that all health professionals are aware of the learnings from the reviews.

Individual Funding Request (IFR)

During 2018/19 we revised the process for managing IFRs and ensure that each application is reviewed by a clinician early in the process. We have produced a new IFR policy, reviewed and updated our IFR webpage, and developed a new information leaflet.

We responded to 1,889 IFR applications for treatments for children and adults. 50 per cent of these were approved by clinicians under the 'prior approval' process and we progressed 76 applications to be considered by clinicians at a full multi-disciplinary Individual Funding Panel. People who have their applications approved go on to receive the treatment requested, such as surgery or counselling. IFR applications will be declined if they do not meet the local policy, which you can read here: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2019/04/IFR-Policy-2019-incl-Appendices-Forms.pdf

Those who have had their applications declined are able to appeal the decision and have their application reviewed again. If the application is declined again, it is likely to be because it does not meet the specified criteria.

We have developed a collaborative working relationship with Swindon and Wiltshire CCGs aligning our clinical policies and forming a joint clinical policy working group.

Adult Continuing Healthcare

During 2018/19 we completed an Adult Continuing Healthcare Maturity Framework self-assessment to identify the areas that need to be improved. This showed us that we need to work more closely with the council, Swindon and Wiltshire CCGs. At a NHS England Leadership Live event in June 2018, we committed to working in partnership with Wiltshire and Swindon CCGs to transform Adult Continuing Healthcare. We have aligned our processes and procedures to support consistent application of the National Framework and reduce unnecessary variation. To ensure that people receive the health care they need through joint packages wherever possible, we work closely with the council on cases where individuals have been assessed as not being eligible for Adult Continuing Health Care.

We are committed to delivering the requirements of the National Framework and have a joint robust action plan with our CHC provider, Virgin Care, to deliver assessments within the required 28 day timeframe. This has resulted in our rates increasing from 23 per cent in April 2018 to the required 80 per cent in January 2019.

To establish whether individuals are receiving the right level of care, we asked our external

auditors to review a number of the Adult Continuing Health Care packages that are provided in their homes. This review has provided us with assurance and shown us which areas need to be made more robust.

Personal Health Care Budgets provide greater opportunities for people and enable them to have a greater choice about the care they receive, and all B&NES residents who are eligible to receive Adult Continuing Healthcare funding and are entitled to a Personal Health Care Budget have been offered one. We have arranged for approximately half of people who are living independently at home to have their packages of care via a Personal Health Care Budget and we have plans to expand Personal Health Budgets to other areas. We also plan to better communicate Adult Continuing Health Care to the public to better understanding and awareness. This will be achieved in a number of ways, including revising the information on our website and creating leaflets.

Children's continuing care and Special Educational Needs or Disability (SEND)

In B&NES, the number of children and young people with complex needs that require specialist statutory support through Education, Health and Care Plans (EHCP) has risen over the past four years. In 2018/19, there were 1,185 children with EHCPs.

During the year, we have worked with the council and in partnership with other key stakeholders to develop an early identification and notification system. This has resulted in earlier identification which means that children and young people receive support at the earliest opportunity. We have put new systems in place to notify GPs of children who have SEND, which has improved the service which the whole family receives and enables young people with a learning disability to access annual physical health checks.

We have reviewed and revised our provision for specialist mental health support for children. This has resulted in a system which aims to improve access and enable parents and children to self-refer. We were pleased that our integrated services for SEND were inspected by Ofsted and the CQC in March 2019 and we are awaiting the feedback. This will be used alongside the regular feedback we receive from families to further improve our services.

During the next year our plans include developing support for children educated outside of school and improving the assessment and support for children with autism. We are working with other agencies to ensure children and young people receive the right support in educational settings to enable them to progress and improve the transition to adult services.

Complex Discharges

Unnecessarily prolonged stays in hospital can result in a number of problems for individuals, such as risk of infection, sleep deprivation and episodes of acute confusion. National research has found that for those most at risk, a stay in hospital of over 10 days will result in 10 years of muscle ageing. To help reduce health inequalities and ensure that

prolonged hospital stays for those with complex packages of care are avoided, we have been working with the RUH to ensure that people are able to leave hospital as soon as they are well enough. This has involved developing a 'Joint Protocol for Adult Discharge Pathways for Health and Social Care and Associated Funding Arrangements', which helps to ensure that discharges aren't delayed due to funding issues.

We work hard to ensure that people who are nearing the end of their life and have Continuing Health Care Fast Track funding have their packages of care arranged as soon as possible. In January 2019, we reviewed the process for assessing eligibility and completed an audit to ensure that we are following the National framework correctly.

Quality Assurance

Commissioning for Quality and Innovation (CQUIN) is offered on an annual basis to all commissioned services. CQUINs account for 2.5 per cent of a provider's total income for agreed quality improvement schemes and allow our partners to work at scale to facilitate change. The aim of the CQUIN scheme is to make sure quality is always part of the discussion between commissioners and providers. Providers of acute hospitals and ambulance, community and mental health services that use standard national contracts are also required to have a CQUIN scheme.

Further information about the national CQUIN schemes for 2017-19 can be accessed via the NHS England CQUIN website:
https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

Highlights from this year's CQUINs include:

- Improving the uptake of the flu vaccination for frontline clinical staff
- Promoting the timely identification and treatment of sepsis in emergency departments and acute inpatient settings
- Improving services for patients with mental health needs who go to A&E
- Improving young people's experience of transition and involvement in Children and Young People's Mental Health Services
- Promoting that our providers offer screening, advice and referral interventions for smoking and alcohol
- Improving the assessment of wounds.

The system-wide CQUIN panel, which includes quality lead representation from BaNES, Swindon and Wiltshire CCGs, has enabled a more collaborative review of the providers of CQUINs. This has supported an improved understanding of work streams and outcomes across the wider health community.

Patient Safety

We have a responsibility to ensure that the services we commission are safe. We strive to ensure that individuals are not harmed when receiving healthcare, though occasionally, a Serious Incident or Patient Safety Incident occurs.

All serious incidents reported by provider organisations are reviewed at our Serious Incident Panel to ensure that a robust investigation is undertaken. Feedback is given to the provider organisation to promote learning and help prevent the incident from happening again in the future. We review whether there are any:

- Lessons that could be learnt by another organisation
- Learnings about strengths and weaknesses of the wider system
- Quality Improvement projects that could be undertaken or any issues that require further research and development

If an incident is identified, we ensure that our providers meet the statutory requirements under the Health and Social Care Act 2008 to inform the individual and provide a meaningful apology to those affected.

Quality Improvement

The National Early Warning Score (NEWS) enables the early identification of medical deterioration, and consequently facilitates timely and appropriate treatment. NEWS2 is the updated version of the tool which was launched in 2018.

The RUH, Virgin Care, BEMS, Circle Bath, BMI Bath Clinic, and SWAST are currently using either NEWS or NEWS2. In collaboration with the Academic Health Science Network, during 2018/19 we implemented NEWS2 across B&NES Primary Care services and Care Homes (Nursing).

As part of the project, the CCG facilitated training on NEWS in all Care Homes within B&NES. To date, 86 per cent of care homes have implemented NEWS2 and 92 per cent of residential homes received training. In addition, NEWS training took place at a local primary care forum and at the GP education sessions.

Research and Development

Bath Research and Development (BRD) provides us and other local primary and community providers in the region with research management and governance systems. This service, which is based at the University of Bath, is fully funded by the National Institute for Health Research. Research performance is reported to the BaNES CCG Quality Board.

Our Director of Nursing is the research and development lead for BaNES CCG and also attends BRD Executive meetings, where wider research matters are discussed. In the previous year, 594 members of the BaNES community were recruited to portfolio studies via their local GP.

Better Care Fund

2018-19 saw the second year of the Better Care Fund (BCF) plan 2017-19. Our plans 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[3] and our two-year community services review, *Your care, Your way*.[4] This strategy sets out our commitment to maintaining independence and supporting people at all stages of their lives and the Better Care Fund is the vehicle for the pooled budget that supports the delivery of that strategy.

Our focus continues to be on reducing non-elective admissions, reducing delayed transfers of care from hospital, 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. 2018-19 has seen significant pressure on non-elective admissions, however the plan is demonstrating an impact on delayed transfers of care (DTOCs), permanent admissions to care homes and a really positive increase in the number of older people still at home after reablement. These outcomes have been delivered through a focus on the following priorities:

- Further investment in our Home First service which now supports up to 31 people, 7 days a week to go home from hospital as soon as they are ready

- An innovative new pilot to support people with delirium (temporary confusion) to leave hospital on the Home First pathway to enable them to recover at home before a decision is made about their long term care needs

- Continuing to operate our 5 Discharge to Assess beds to allow people further time in a care home setting with reablement before a decision is made about long term care needs

  Supporting our social care teams to develop the Three Conversations model of assessment and support planning which helps to work on people's strengths and look at involving their family and community in their lives as much as possible

- Commissioning a brokerage service to help people going into care homes from hospital to choose a home and navigate the care home system – this has supported people who fund their own care, those at end of life and those supported by the local authority

- Employing a new Trusted Assessor who works with care homes and hospital wards to help carry out assessments for care homes, giving them both extra support in this process and reducing the time spent waiting for assessments to take place

- Continuing to invest in the Falls Response service which involves an Occupational Therapist and Paramedic visiting and assessing people who have fallen at home to help prevent any unnecessary admissions to hospital.

[3] https://www.bathnes.gov.uk/services/neighbourhoods-and-community-safety/working-partnership/health-and-wellbeing-board
[4] https://www.bathandnortheastsomersetccg.nhs.uk/get-involved/project/ycyw

The focus this year has been about care in the right setting – assessing people in their own homes where possible, getting people home to continue recovery, and supporting them to transfer to other settings smoothly if they cannot go home with a continuous focus on identifying people's strengths and independence. Many of the schemes above were also supported by investment from the Improved Better Care Fund (iBCF) and social care Winter Pressures grant funding which has helped to provide additional resource to the health and care sector over the winter period. In addition, many of the projects developed in 2018-19 were informed by the High Impact Change Model guidance published in 2017 – this guidance is due to be refreshed in 2019-20 with a likely focus on avoiding unnecessary hospital admissions. This will be a key focus for B&NES in 2019-20.

Optimising our use of medicines

Our GPs write 3.9 million prescriptions, at a cost of £24 million annually, for people in B&NES. Our medicines optimisation team works closely with general practice to make sure these medicines are safe and effective for individuals, 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 another exceptionally good year for delivering savings in the medicines budget, including a forecast £1.1 million annual saving between our primary and secondary care 'high cost' medicines prescribing budgets. These savings have been achieved by continued use of IT systems that help ensure clinicians choose the most appropriate medicines at the point of prescribing. We have also worked with prescribers and individuals to achieve a high uptake of biosimilar medicines in secondary care, which are less expensive than their branded counterparts.

The CCG's medicines optimisation team has continued to focus on the ten priorities outlined in the CCG Medicines Strategy, which was launched in 2016. The strategy can be read here:
https://www.bathandnortheastsomersetccg.nhs.uk/documents/strategies/medicines-optimisation-strategy-2016-20

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 medicines for anticoagulation to reduce the number of strokes.

- Implementation of the PINCER initiative to identify those at risk of harm from medication errors, supporting the national medication safety agenda.

- Collaborative work with specialist colleagues in diabetes to improve preconception management for women with diabetes planning pregnancy and better achievement of blood pressure targets in the broader diabetic population.

- Working with community pharmacists to help identify medicines people may not require on their repeat prescriptions.

- An innovative prescription ordering direct service via two groups of GP practices, to reduce medicines waste and streamline process for individuals to order their medicines.

- Developing the pharmacy workforce within primary care.

Equality and Diversity

Our work is always carried out in line with the Equality Act 2010, and we are committed to eliminating all forms of discrimination, providing equal opportunities and protecting the human rights of those living in B&NES. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

Through the use of Equality Impact Assessments, we have adopted a robust approach that ensures that the impact of decisions which may affect individuals are analysed before their implementation. This tool allows us to assess the impact of our proposals on each of the nine protected groups which are highlighted in the Equality Act 2010, which in turn enables us to guarantee that our services result in high-quality health care that is fair, accessible to all and meets the needs of our diverse communities. Equality impact assessments are an important part of commissioning projects, and ours are published here:https://www.bathnes.gov.uk/services/your-council-and-democracy/equality-and-diversity/equality-impact-assessmentsequality-0

We require all of our healthcare service providers to comply with 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.

As the number of CCG employees is below the threshold of 150, we are not required to publish equality data about our staff as it is difficult to publish some aspects of the data without compromising staff confidentiality. All our staff are required to undertake three yearly training on equality and diversity.

We are committed to improving our Equalities Data, Intelligence data, and our use of equality analysis data in our commissioning cycle. To help improve our equality data, we are building stronger relationships with protected groups and communities to better understand and fulfil their needs.

Sustainability Report

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

During 2018/19 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 Procurement policy

- 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 access to and use of Skype and conferencing facilities to reduce travel

- Extension of our paperless approach through continued 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 and focussed action with NHS Property Services to address building and facilities improvement

During 2019/20 our focus will be on the following objectives:

- Delivering the fourth 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 joint working with Bath & North East Somerset Council who have declared a Climate Emergency. The Council have pledged to provide leadership to enable Bath & North East Somerset to become carbon neutral by 2030.

- Continued engagement with the BaNES, Swindon and Wiltshire 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 2018/19 from all our activities including services commissioned by us is 53,854 tonnes of carbon dioxide equivalent emissions (tCO2 e) (2017/18 50,893 tCO2 e). Within this figure, 53,266 tCO2 e are related to healthcare services commissioned by the CCG (2017/18 50,309 tCO2 e) and a further 527 tCO2 e (2017/18 519 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 where we exercise a commissioning function on behalf of NHS England.

The main reason for the increase in carbon emissions from 2017/18 to 2018/19 is an increased spend by the CCG on the commissioning of healthcare.

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 2018/19, the CCG as a corporate body produced 70.8 tCO2 e compared to 68.8 tCO2 e in 2017/18.

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

CO2 Emissions (tonnes of CO2e)	2018/19	2017/18	Change in tCO2e	% Change
Paper Products	5.3	10.2	-4.9	-48.2%
Information and communication technologies	2.3	3.2	-0.9	-27.8%
Food and Catering	2.1	2.2	-0.1	-6.4%
Water and sanitation	0.3	0.3	0.0	-12.1%
Waste products and recycling	2.0	1.9	0.0	1.0%
Travel	11.9	12.2	-0.3	-2.5%
Electricity	18.3	18.6	-0.3	-1.8%
Gas	28.7	20.1	8.7	43.1%
Total	**70.8**	**68.8**	**2.0**	**3.0%**

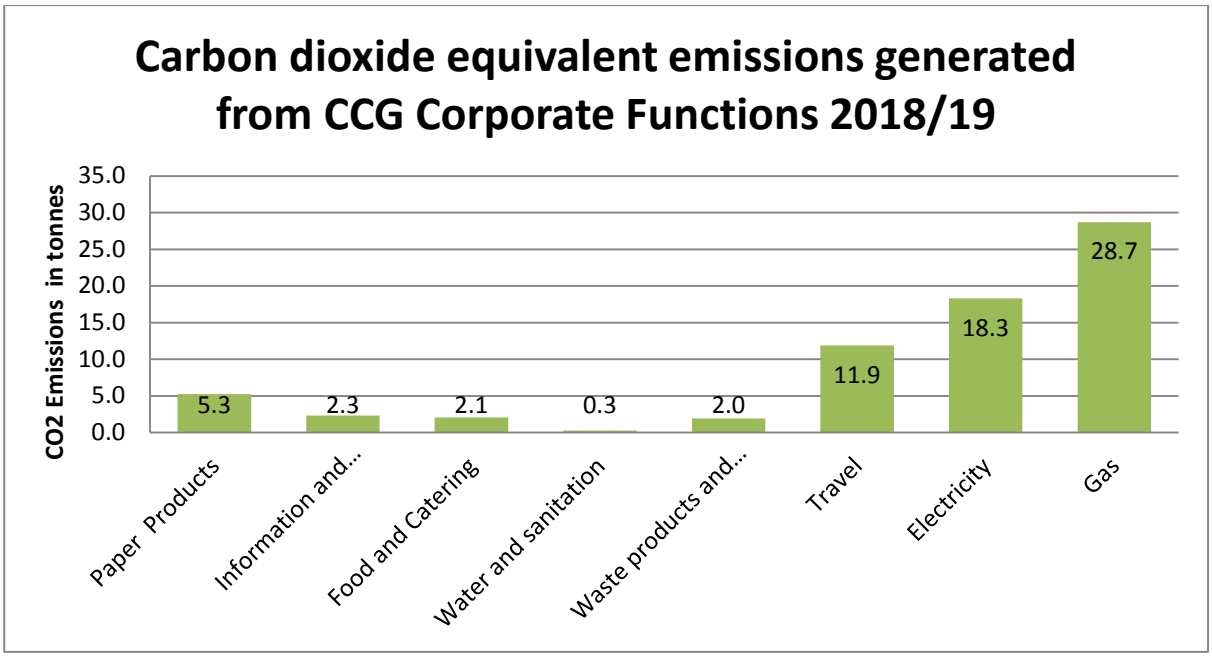
The increase in emissions relating to Gas is a result of Midford House being included in the analysis in 2018-19, as CCG staff now occupy an area of this building.

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 decreased, although the CCG continues to invest in the technology required to support paperless working.

The fall in emissions related to travel can also be credited to the investment in ICT as employees at the CCG adopt Skype and conferencing facilities in order to reduce travel.

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

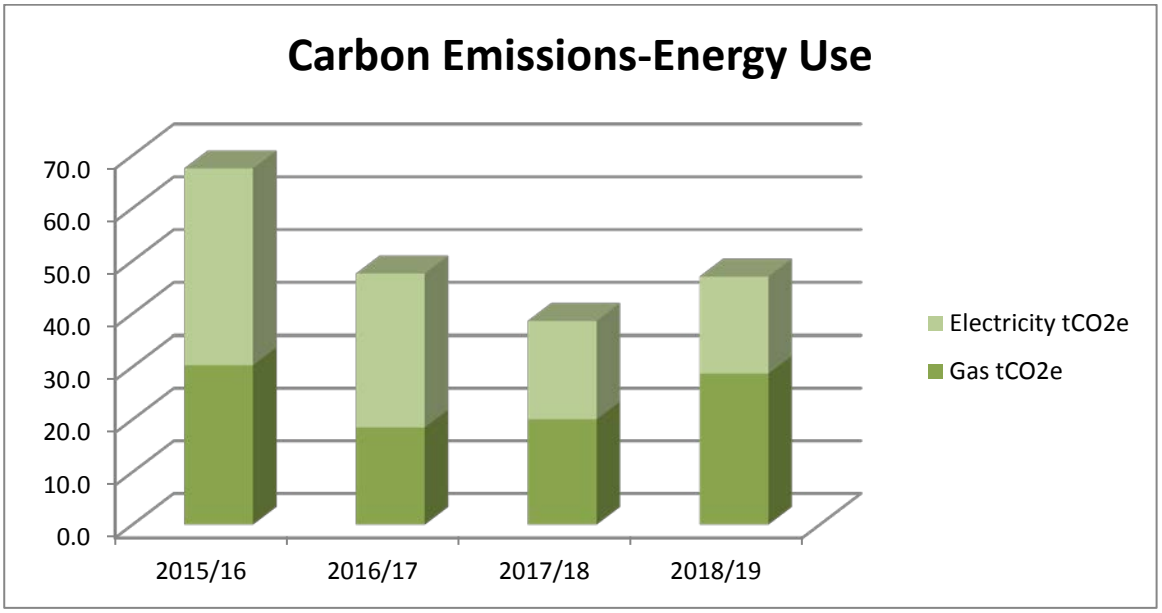
The chart below illustrates the carbon impact of our actions as a corporate body during 2018/19.



Energy

The table below and following chart show our expenditure on energy for 2018/19 as compared to the previous three years, and the resulting modelled carbon emission impact. The data is based on apportioned usage across the St Martin's Hospital site. As noted above, gas and electricity consumption attributed to the CCG has increased due to the new occupancy of part of Midford House. Despite this the emissions for Electricity have fallen as a result of the Electricity from Grid becoming greener, with a greater use of renewable energy sources.

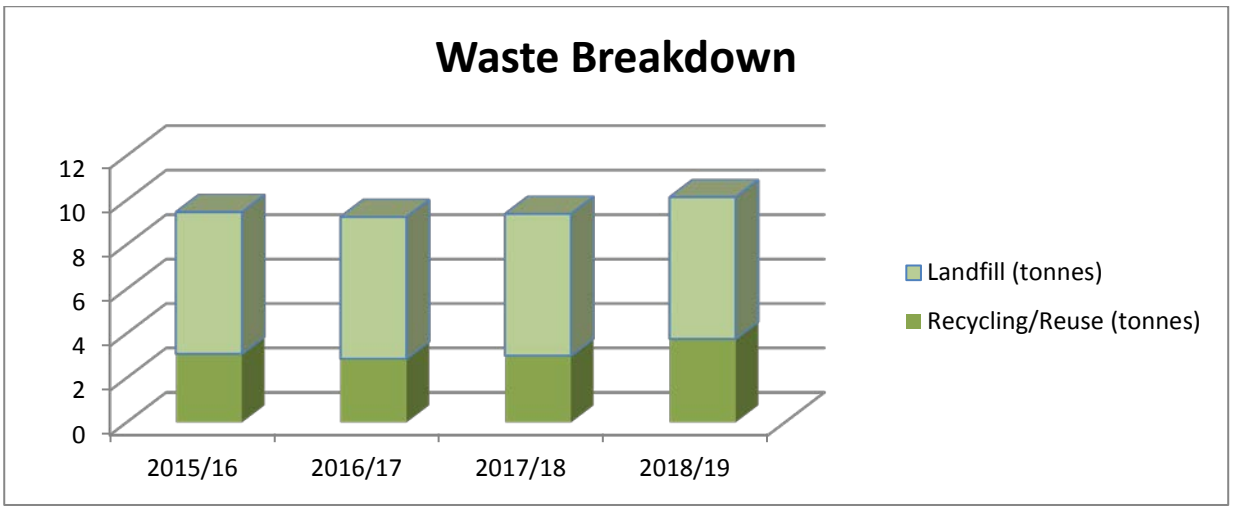
Resource		2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	144,586	88,393	94,549	135,219
	tCO2e	30.3	18.5	20.0	28.7
Electricity	Use (kWh)	64,673	56,330	41,822	51,924
	tCO2e	37.2	29.1	18.6	18.3
Total Energy CO2e		67.5	47.6	38.6	47.0
Total Energy Spend		11,663.0	10,103.0	7,948.0	12,738.0



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 the cost of recycling. Our percentage of waste recycled has improved as a percentage of total waste.

Waste		2015/16	2016/17	2017/18	2018/19
Recycling/Reuse	(tonnes)	3.08	2.86	3.00	3.75
	tCO2e	0.06	0.06	0.07	0.09
Landfill	(tonnes)	6.38	6.38	6.38	6.38
	tCO2e	1.56	1.86	1.86	1.86
Total Waste (tonnes)		9.46	9.24	9.38	10.13
% Recycled or Re-used		32.56%	30.95%	31.98%	37.02%
Total Waste tCO2e		1.62	1.92	1.93	1.95



Water

The table below shows our expenditure on water and sewerage during 2018/19 as compared to the previous three years. As with energy, the data is based on apportioned usage across the St Martin's Hospital site. Expenditure has increased in 2018/19 as a reflection of including Midford House in the workings, and an increase in the amount apportioned to the CCG as a reflection of greater occupancy, although usage has decreased, suggesting this is due to price increases.

Water		2015/16	2016/17	2017/18	2018/19
Mains	m3	306	548	360	322
	tCO2e	0.28	0.50	0.32	0.29
Water & Sewage Spend		£1,103	£1,979	£1,014	£1,796

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 main NHS providers of services to our population have minimum or poor scores, although University Hospitals Bristol NHS FT does have Sustainable Development Management Plan and Healthy Travel Plan in place. 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 duties for the year.

We closed the year with a total funding allocation (Revenue Resource Limit) of £271.53m and operated within this for 2018/19, achieving a small surplus of £0.039m.

Savings schemes of £6.19m had been planned in 2018/19, of which £5.57m (90%) has been delivered through a combination of work programmes planned at the start of the year, and additional actions. The savings delivered included schemes to reduce avoidable referrals and emergency visits to hospital by developing out of hospital services and enabling people to better manage their health, and measures to improve the effective use of medicines and reduce avoidable waste. This released valuable resources used to fund cost pressures and a range of investments during 2018/19 to support the savings delivery and overall CCG strategy.

During 2018/19, BaNES CCG acted as host for income and expenditure transactions and for employing some staff on behalf of the BaNES, Swindon and Wiltshire Strategic Transformation Partnership (BSW STP). Control of this income and spend sits equally with all core partner organisations within BSW so in line with correct accounting practice these have been excluded from the accounts.

The recurrent administration resource budget of £4.28m has been spent in full but not exceeded.

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 £0.039m

	2018/19	2017/18
	£000	£000
Performance for the year ended 31 March:		
Total Net Operating Cost for the Financial Year	**271,492**	258,325
Revenue Resource Limit	**271,531**	259,796
Underspend Against Revenue Resource Limit	**39**	1,471

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.

	2018/19	2017/18
	£000	£000
Performance for the year ended 31 March:		
Administration Cost for the Financial Year	**4,282**	4,210
Administration allocation	**4,282**	4,257
Underspend Against Allocation	**0**	47

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.

	2018-19 Number	**2018-19 £'000**	**2017-18 Number**	**2017-18 £'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the year	5,641	104,336	4,900	102,542
Total Non-NHS Trade invoices paid within target	5,561	103,619	4,834	101,826
Percentage of Non-NHS Trade invoices paid within target	**98.58%**	**99.31%**	**98.65%**	**99.30%**
NHS Payables				
Total Non-NHS Trade invoices paid in the year	2,882	139,837	2,845	129,786
Total Non-NHS Trade invoices paid within target	2,860	139,726	2,824	129,760
Percentage of Non-NHS Trade invoices paid within target	**99.24%**	**99.92%**	**99.26%**	**99.98%**

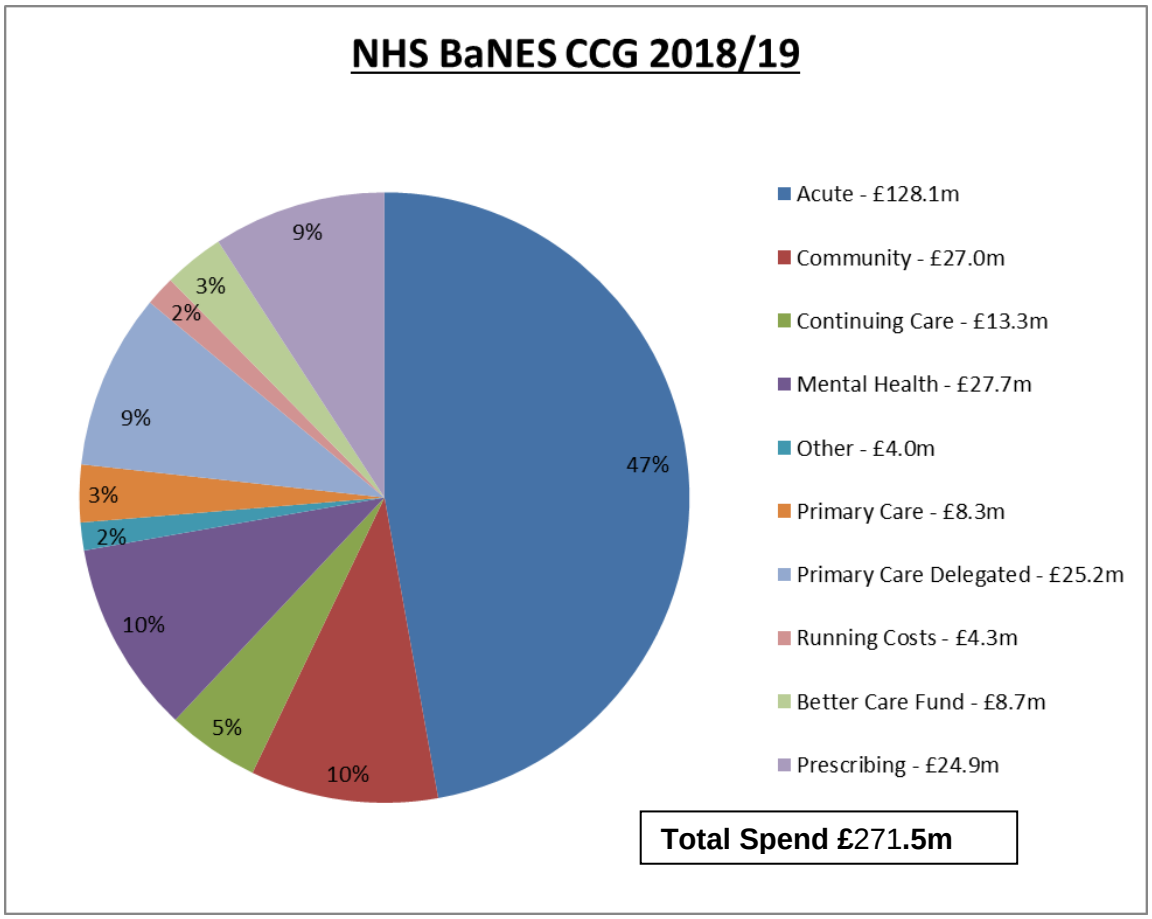
Cash position

Our financial statements show cash held of £0.001m as at 31 March 2019. The CCG was required to have a balance no greater than 1.25% of the cash value drawn down in March, which equates to £0.25m 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 registered with BaNES GPs. The chart below shows the types of services provided and illustrates how much we spent on each during 2018/19. Acute healthcare makes up the highest percentage of expenditure (47%), with the next largest areas of expenditure being Primary Care (including Delegated Commissioning) followed by Mental Health (including Learning Disability) Community Services and Prescribing.

In line with the CCG strategy, we envisage a future shift in healthcare spend from Acute to Primary Care and Community settings and increased investment in Mental Health services as sustainable services are developed within the context of the NHS Long Term Plan.



Future Financial Position

The CCG has submitted a challenging but realistic financial plan for 2019/20 which plans to deliver a breakeven position. Planned net savings of £6.24m are required to offset increasing costs and activity pressures and to support priority investments. The financial plan is in line with our Operating Plan for the 2019/20.

Financial Statements

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

ACCOUNTABILITY REPORT

Tracey Cox
Chief Executive Officer
23 May 2019

Corporate Governance Report

The purpose of this corporate governance report is to explain the composition and organisation of our governance structures, and how they support the achievement of our objectives.

Members Report

As a Clinical Commissioning Group (CCG), we are a clinically-led statutory NHS body. We are responsible for the planning and commissioning of health care services for the population in our local area, i.e. the geographical area covered by the Bath and North East Somerset Council. We are a general practice membership organisation: all practices who provide primary medical services to a registered list of patients in our area are eligible for membership of the BaNES CCG, and we are accountable to them.

Our member practices are grouped in clusters, i.e. groupings of member practices within the geographical area of our CCG which enables a particular focus on the health and care needs within the cluster. The GP Board members are also the cluster leads, which is another mechanism through which we enable our member practices to be actively involved in our governance.

In 2018/19, 24 GP practices formed our membership:

Three Valleys Healthcare (Cluster Lead: Dr Liz Hersch)

- Chew Medical Practice
- Elm Hayes Surgery
- Harptree Surgery
- Hope House Surgery
- Somerton House Surgery
- St Chads Surgery
- St Mary's Surgery
- Westfield Surgery

Bath Aqua Plus (Cluster Lead: Dr Daisy Curling)

- Batheaston Medical Centre
- Bath University Medical Centre
- Fairfield Park Health Centre
- Heart of Bath Medical Partnership
- Monmouth Surgery
- The Pulteney Practice
- Widcombe Surgery

Bath Sulis (Cluster Lead: John Moon)

- Combe Down Surgery
- Grosvenor Surgery
- Newbridge Surgery
- Rush Hill Surgery
- St Michael's Surgery

Keynsham (Cluster Lead: Dr Bryn Bird)

- St Augustine's Surgery
- Temple House Practice
- West View Surgery

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 BaNES as a whole. Each practice nominates a GP as its representative on our Council of Members. This group meets at least twice a year and:

- represents the interests of local GPs;
- is consulted, and advises, on proposed amendments to the CCG's Constitution;
- holds the Board members, both individually and collectively, to account for their performance;
- informs the CCG's commissioning plans;
- agrees initiatives to improve the quality and outcomes of patient care and better use of resources.

The Council of Members is chaired by the Clinical Chair of the CCG. During 2018/19 the Council of Members met on three occasions and held a total of five ballots:

Date	Item	Action
Meeting – 15 May 2018	Presentation of Annual Report Accounts (ARA) 2017/2018	Delegated authority to the CCG Board to approve the ARA on recommendation of the Audit Committee
Electronic vote – June 2018	Vote : Election of GP Board member	Appointment of Dr Bryn Bird as GP Board member
Meeting – 11 September 2018	STP update and strategic direction	Noted
Electronic vote – September 2018	Vote : Election of GP Board member	Re-appointment of Dr Daisy Curling as GP Board member
Electronic vote – January 2019	Consultation and vote : Adoption of the NHSE model constitution	Supported the adoption of the NHSE model constitution
Meeting – 20 March 2019	Presentation of Draft Operational Plan 2019/20	Delegated authority to the CCG Board to approve the final Plan on recommendation of the Finance & Performance Committee

Our Governing Body (the Board)

The main function of our Board is to ensure that the CCG has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with accepted principles of good governance – in doing so our Board and the CCG as a whole build patients', stakeholders' and the public's confidence

that their health and healthcare is in safe hands. Our Board is responsible for ensuring leadership through effective oversight and review. It sets the strategic direction of the CCG and oversees the delivery of our strategic objectives and our work towards achieving our constitutional and organisational targets. Organisational structure and accountabilities are clear and well defined.

Throughout the business year 2018/19 this has been achieved through the arrangements we describe below.

Composition of our Governing Body

BaNES CCG has a properly constituted clinically-led Board, with the appropriate clinical, managerial and lay member skill mix, and which is accountable to our Members via the Council of Members' meetings and the cluster arrangements. Our Board comprises:

- The Chair;
- The Accountable Officer;
- The Chief Finance Officer;
- A Secondary Care Specialist;
- A Registered Nurse;
- Three lay members:
    - one who leads on finance and audit matters;
    - one who has knowledge about the CCG area enabling them to express an informed view about discharge of the CCG functions.
    - one who leads on patient and public participation matters
- Five GP members
- One Practice Manager member

Dr Ian Orpen has been the CCG's Clinical Chair throughout the business year 2018/19, from 1 April 2018 through to the signing of this Annual Report and Accounts.

Tracey Cox has been the CCG's Chief Officer (the Accountable Officer) throughout the business year 2018/19; during that time, Tracey also was the interim Senior Responsible Officer for the BaNES, Swindon and Wiltshire (BSW) STP. On 1 March 2019, Tracey was appointed as Chief Executive of the BaNES, Swindon and Wiltshire CCGs and STP, following a decision taken by the three CCGs in October/November 2018 to maintain the three separate CCGs, but with a single management team, (incorporating the STP) and streamlined governance arrangements. As part of the re-structure the two remaining Accountable Officers have temporarily been appointed as Deputy Chief Executives for the Swindon and Wiltshire CCGs respectively, until the new single management team is in place.

As part of the streamlined governance arrangements, each of the CCGs has agreed to adopt the new Model CCG Constitution[5]. At the time of writing this annual report, NHS England had reviewed, and signalled approval in principle, of the three CCGs' updated constitutions, which were submitted to NHS England following consultation with, and agreement by, the respective memberships.

[5] https://www.england.nhs.uk/publication/nhs-clinical-commissioning-group-consitution/

In summary, in 2018/19 our Board has had the following members – personal profiles can be found on our website, https://www.bathandnortheastsomersetccg.nhs.uk/about :

Board Members	
Dr Ian Orpen	Clinical Chair
Tracey Cox	Chief Officer
Dr Ruth Grabham	Medical Director
Lisa Harvey	Director of Nursing & Quality / Registered Nurse
Sarah James	Chief Financial Officer
Dr Tim Sephton	GP
Dr Elizabeth Hersch	GP
Dr Bryn Bird *(from 1 August 2018, following a vacancy from April to July 2018)*	GP
Dr Daisy Curling	GP
John Moon	Practice Manager
John Holden	Lay Member (audit and governance) / Vice Chair
Suzannah Power	Lay Member (patient and public involvement)
Katie Hall	Lay Member (quality)
Vacant	Secondary Care Specialist Consultant

Our **Executive Team**, supporting Tracey Cox in her role as Chief Officer / Chief Executive Officer, has throughout the business year 2018/19 comprised the following individuals, who have either been members of the Board (*), or have regularly attended Board meetings in a non-voting capacity:

Corinne Edwards	Interim Chief Operating Officer, BaNES CCG *(from November 2018)* Director of Acute and Primary Care Commissioning, BaNES CCG *(till October 2018)*
Catherine Phillips	Acting Director of Acute Commissioning, BaNES CCG *(from November 2018)*

Dr Ruth Grabham (*)	Medical Director
Lisa Harvey (*)	Director of Nursing & Quality
Sarah James (*)	Chief Financial Officer
Jane Shayler	Director, Integrated Health & Care Commissioning, BaNES CCG & B&NES Council
Caroline Holmes	Interim Director, Integrated Health & Care Commissioning, BaNES CCG & B&NES Council *(from January 2019)*
Julie-Anne Wales	Head of Corporate Governance & Planning, BaNES CCG

Our Constitution

CCGs are legally obliged to set out their agreed governance arrangements in a publicly available Constitution. The Constitution sets the roles and responsibilities of, and the relationship between the CCG's Members, the Board and Executives, and outlines the structures and processes (our governance) by which we make decisions and are held to account.

Our Constitution is published on our website:
https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/nhs-banes-ccg-constitution-june-2016

Following engagement and consultation with our member practices through December 2018 and January 2019, and subject to approval by NHSE, we are adopting the NHSE Model Constitution as issued in September 2018[6]. This will enable us to collaborate more closely and to co-commission health and care services jointly with local authority partners and neighbouring CCGs, and will streamline our governance arrangements to support collaboration at both a strategic and local level. Our close alignment of governance arrangements with neighbouring Swindon and Wiltshire CCGs will be reflected in a Joint Governance Handbook which we will publish alongside the Constitution, and which will provide further detail of how we govern ourselves. The Handbook will contain the Scheme of Reservation and Delegation (SoRD) which outlines matters that are reserved for decision-making by the membership, by the Board, and those authorities delegated to committees and/or individuals. Decisions reserved to the Board relate to the establishment of, and changes to, the CCG's strategy, financial stewardship, risk management, and organisational culture.

In March 2019, the Board together with its Swindon and Wiltshire counterparts agreed a joint governance framework as a further step towards consolidating the BaNES, Swindon and Wiltshire (BSW) Sustainability and Transformation Partnership (STP). This framework established the principles for aligned and shared governance and decision-making structures and processes, as appropriate, while maintaining each CCG as a clearly

[6] NHS Clinical Commissioning Group Constitution, https://www.england.nhs.uk/publication/nhs-clinical-commissioning-group-consitution/

independent organisation in its own right. The framework sets out the principles for the operation of committee meetings in common and for the formation of joint committees, where permitted, by the three CCGs.

The Board's performance and effectiveness

Throughout the year, the Board has provided clear strategic leadership and accountability for the organisations' business and activities, in what was a challenging year in terms of strategic, organisational, financial, demand and operational pressures on the healthcare system.

The Board operates an annual cycle of business, which ensures that standard assurance and approval items are considered at appropriate times in the business year. These items include:

- Strategy development
- Oversight and delivery of the Operating Plan
- Reporting on, and oversight of, CCG finances
- Reporting on, and oversight of 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
- Scrutiny of the Governing Body Assurance Framework (BAF) and the Risk Register
- Development of the Primary Care Strategy
- Reports from Board committees

As per our Constitution, our Board is required to meet on a regular basis, normally six times per year (and no more than two months apart). During 2018/19, the Board held six meetings in public. The Board's meetings focussed on, and took key decisions regarding, commissioning at scale and the CCG's strategic alignment at system-level with Swindon and Wiltshire CCGs; integrated commissioning with B&NES Council; mental health services provision; maternity services review; the NHS long-term plan; and EU Exit Operational Readiness. We publish on our website the papers for all our Board meetings held in public, https://www.bathandnortheastsomersetccg.nhs.uk/get-involved/meeting/public-board-meetings .

Informal Board seminar sessions alternate with the Board meetings in public. Seminar sessions provide an important opportunity for Board members to discuss matters of policy and strategy, directly informing and shaping the formal business of the organisation. Particular focus in 2018/19 was on integrated commissioning, commissioning at scale, Primary Care Networks, and the relationship with some of the CCG's key providers/contractors.

In May 2018, the Board undertook an externally facilitated Board Development Workshop. The Board has been implementing the recommendations for enhanced, good meeting practice throughout the year.

The Board reviews its terms of reference and those of its committees annually. In adopting the NHSE model constitution (issued 2018) in January 2019, the Board has effectively

reviewed and updated its Terms of Reference.

Board members also serve on Board committees. Through these arrangements, we maintain clear lines of accountability from committees to the Board, and tie committees to the provisions made in our Constitution and Standing Orders with regards to decision-making.

As part of our assessment of the Board's and its committees' effectiveness, the table below presents Board members' and senior officers' attendance at meetings in 2018/19:

		Board and Board Committee membership and attendance in 2018/19						
Name	**Position**	**Board (public meetings)**	**Audit Committee**	**Remuneration committee**	**Primary Care Commissioning**	**Joint Commissioning Committee**	**Finance and Performance Committee**	**Quality Committee**
Board members								
Dr Ian Orpen	Clinical Chair	6/6	n/a	4/4	n/a	6/9***	7/9	n/a
Dr Ruth Grabham	Medical Director	6/6	n/a	n/a	3/4	8/9	4/9	3/3
Dr Liz Hersch	GP Board member	4/6	n/a	n/a	n/a	6/9***	n/a	n/a
Dr Daisy Curling	GP Board member	4/6	n/a	n/a	n/a	6/9***	n/a	2/3
Dr Tim Sephton	GP Board member	3/6	n/a	n/a	n/a	7/9***	n/a	n/a
Dr Bryn Bird	GP Board member *(from August 2018)*	3/6*	n/a	n/a	n/a	4/9***	n/a	n/a
John Moon	Practice Manager Board member	6/6	n/a	n/a	4/4	9/9***	n/a	n/a
John Holden	Lay member (Audit and governance)	6/6	6/6	4/4	3/4	n/a	8/9	n/a
Katie Hall	Lay member	5/6	5/6	3/4	4/4	n/a	n/a	3/3
Suzannah Power	Lay member	5/6	6/6	4/4	3/4	n/a	n/a	2/3
Tracey Cox	Chief Executive Officer	4/6	3/6	2/4	n/a	3/9	6/9	1/3
Sarah James	Chief Financial Officer	5/6	5/6	n/a	1/4	9/9	8/9	n/a
Lisa Harvey	Director of Nursing and Quality/Registered Nurse	6/6	4/6	n/a	2/4	7/9	8/9	3/3
Executive officers in attendance (non-voting)								
Corinne Edwards	Interim Chief Operating Officer, BaNES CCG *(from November 2018)* Director of Acute and Primary Care Commissioning, BaNES CCG *(till October 2018)*	6/6	n/a	n/a	4/4	8/9	9/9	n/a
Jane Shayler	Director, Integrated Health	4/6	n/a	n/a	n/a	6/9	6/9	n/a

	and Care Commissioning, B&NES Council and BaNES CCG (*till December 2018*)							
Caroline Holmes	Interim Director, Integrated Health and Care Commissioning, B&NES Council and BaNES CCG (*from January 2019*)	1/6**	n/a	n/a	n/a	2/9	1/9	n/a
Julie-Anne Wales	Head of Corporate Governance and Planning	6/6	3/6	n/a	n/a	6/9	6/9	n/a
B&NES Council officers in attendance								
Mike Bowden	Strategic Director People and Communities, B&NES Council	4/6	n/a	n/a	n/a	8/9[+]	n/a	n/a
Bruce Laurence	Director of Public Health, B&NES Council	5/6	n/a	n/a	n/a	8/9[+]	n/a	n/a

* Dr Bird was appointed to the Board in August 2018, and attended 3 out of the 4 public Board meetings that took place following his appointment

** Mrs Holmes attended 1 out of the 2 public Board meetings that took place since she took the position of Interim Director, Integrated Health and Care Commissioning

***GP members of the Board, incl. the Chair, and the Practice Manager Board member attend the Joint Commissioning Committee meetings for clinical agenda items.

[+]Mike Bowden and Bruce Laurence are members of the Joint Commissioning Committee and have voting rights.

Board Committees

The Board is supported in fulfilling its duties by six committees that it formally established, and to which it delegated authority to act on the Board's behalf, as appropriate and permitted.

The Board receives regular reports from each of its committees on the matters discussed, the business transacted at each of the committees' meetings, and about matters which the respective committee wishes to bring to the Board's particular attention, including recommendations to the Board for decision, as appropriate in view of the SoRD. Where appropriate and not precluded by confidentiality or other valid considerations, meeting minutes are available for Board members' review.

Statutory Committees

Throughout the business year 2018/19, the Board maintained the following statutory or mandated committees:

- the Audit Committee;
- the Remuneration Committee;
- the Primary Care Commissioning Committee.

The full Terms of Reference of the statutory Audit, Remuneration, and Primary Care Commissioning Committees are published in our Constitution.

Audit Committee

The Audit Committee, which is accountable to the Board, is chaired by a Lay Member of the Board. It provides the Board with an independent and objective view of the CCG's compliance with its statutory responsibilities, and 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;
- monitoring the assurances that the Board receives;
- 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 external and internal auditors and the CCG's response;
- and monitoring the arrangements for and outputs of the CCG's financial reporting systems.

The committee can, where required, request legal and other independent professional advice.

Throughout 2018/19, the CCG Board's lay members formed the membership of the Audit Committee; the below overview shows regular attendees of Audit Committee meetings also:

Members	
John Holden	Lay Member (audit and governance) and Committee Chair
Suzannah Power	Lay Member (patient and public involvement)
Katie Hall	Lay Member (quality)
In Attendance (no voting rights)	
Tracey Cox	Chief Officer
Sarah James	Chief Financial Officer
Lisa Harvey	Director of Nursing & Quality
External Audit Representative	Grant Thornton
Internal Audit Representative	KPMG
Counter Fraud and Security Management specialists	TIAA

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.

The Audit Committee met six times during 2018/19; among other key business, it considered, reviewed and approved, as appropriate:

- internal and external audit plans for the year;
- internal and external auditors' reports and management responses;
- the CCG's Board Assurance framework and risk register;
- Counter Fraud and Security Management reports;
- the Schedule of Losses and Compensations;
- the CCG's Standard of Business Conduct Policy, Register of Gifts and Hospitality, and policy framework;
- the CCG's Annual Report and Accounts 2018/19, and Letter of Representation 2018/19.

Remuneration Committee

The Remuneration Committee, chaired by a Lay Member of the Board, is accountable to the Board. It makes recommendations to the Board about the remuneration, fees and other allowances (including pension schemes) for employees and other individuals who provide services to the CCG.

The membership of the Remuneration Committee throughout 2018/19 was as follows; the below overview shows regular attendees of Remuneration Committee meetings also:

Members	
John Holden	Lay Member (audit and governance) and Committee Chair
Suzannah Power	Lay Member (patient and public involvement)
Katie Hall	Lay Member (quality)
Dr Ian Orpen	Clinical Chair
In Attendance (no voting rights)	
Jude Champion	HR Business Partner (*till November 2018*)
Andrew Mitchell	HR Business Partner (*from November 2018*)

The Remuneration Committee met four times during 2018/19, and considered, for recommendation to the Board, as appropriate:

- the remuneration of the Accountable Officer, the Chief Financial Officer, the Director of Nursing and Quality, the Interim COO, and the re-banding and subsequent increase in remuneration for the Head of Governance and Planning;
- aligned with its Swindon and Wiltshire counterparts, the remuneration of the CEO for the BaNES, Swindon and Wiltshire CCGs and STP, who was recruited and appointed to the post with effect from 1 March 2019;
- aligned with its Swindon and Wiltshire counterparts, the structure and remuneration of the joined-up BaNES, Swindon and Wiltshire CCGs Executive Management Group.

Primary Care Commissioning Committee (PCCC)

In 2017, NHS England delegated to the CCG authority to exercise primary care commissioning functions. The PCCC was established in accordance with the statutory requirements that come with the delegation of primary care commissioning functions, to enable the members to make collective decisions on the review, planning and procurement of primary care services in BaNES under delegated authority from NHS England, which reports to the Board and to NHS England regarding its delegated primary care commissioning functions.

The membership of the PCCC throughout 2018/19 is shown in Appendix 1 to this section of the Annual Report and Accounts.

The Primary Care Commissioning Committee oversees the work of the Primary Care Operational Group (PCOG), and the primary care work plans established by the CCG as part of the Five Year Forward View and the General Practice Forward View Plan. During 2018/19, the PCCC held four meetings in public, and considered among other key business the CCG's Primary Care Strategy, the CCG's Delegated Commissioning Position Statement, the reconfiguration/merger of two GP practices in Bath, the NHS Long Term Plan, and regular updates regarding Improving Access, Sustainability and Transformation Partnership Primary Care, Quality, and the General Practice Forward View.

Non-statutory committees

In addition to the above statutory or mandated committees, throughout the business year 2018/19 the Board also had the following committees:

- the Finance and Performance Committee;
- the Quality Committee;
- the Joint Commissioning Committee, which has supported and oversee the CCG's and B&NES Council's joint commissioning of health and care services.

Information on the committees' membership is provided in Appendix 1 to this section of the Annual Report and Accounts.

Finance & Performance Committee

The Finance & Performance Committee provides a robust performance framework which proactively manages the CCG's financial, performance and improving value schemes. It regularly reviews key providers' contracts and performance, financial updates and dashboards, QIPP performance and delivery, and Better Care Fund position and performance.

Quality Committee

Our Quality Committee meets quarterly to review the quality assurance data and information on organisations from whom we commission services to ensure the CCG Board are kept apprised of key quality issues.

During the year the committee reviewed and revised the style of data reporting, moving

away from a Red, Amber, Green (RAG) rated dashboard to producing statistical process control (SPC) charts. We wanted to ensure our data reporting is consistent with NHS Improvement's programme of work 'Making Data Count'. By using SPC charts, we are able to tell a story and provide a longer term picture of how our providers are performing against their quality KPIs, identifying any trends or patterns. Furthermore, the Quality Team are better able to understand what data falls within what is expected, when issues need to be addressed with the provider and what opportunities are available for quality improvement projects.

In addition to the Quality Committee meetings we hold Quality Untapped Sessions where we review an organisation in depth. During the year we have held two sessions the first focussing on Virgin Care and the second on Care and Nursing Homes. Quality Untapped Sessions are attended by a wide range of CCG, Council and Healthwatch representatives. The meetings generated meaningful discussion and valuable information sharing, identifying opportunities for further improvement which the Quality Team use to address any immediate action and to inform potential future quality improvement projects.

Joint Commissioning Committee

Bath and North East Somerset Council and Bath and North East Somerset CCG have a shared ambition to work together seamlessly to plan, commission and deliver better quality services. In March 2019, the CCG established an Integration Committee which when it meets together with the Cabinet Committee of B&NES Council is known as the Health and Care Board. The Joint Commissioning Committee is a committee of the Health and Care Board.

The Joint Commissioning Committee is a key instrument to embed our integrated health and care agenda. Its key responsibilities include the review of joint service strategies, plans and performance and risk across the CCG and Council partnership; the review of savings and delivery plans by both the CCG and the Council; the development of integrated commissioning; the provision of a forum for delegated decision-making on joint commissioning plans and/or oversight of decisions being recommended to other decision-making bodies.

The committee regularly receives and reviews the Integrated Quality and Performance Report, finance and savings programme reports from the CCG and Council, and Better Care Fund update reports. It makes key commissioning decisions, under delegated authorities jointly from the CCG and the Council, regarding the health and care services provision in Bath and North East Somerset.

Health and Care Board

The CCG's Clinical Chair, Dr Ian Orpen, co-chairs our local Health and Care Board alongside the Council Leader Cllr Tim Warren. The Board's membership includes Cabinet members and officers from Bath & North East Somerset Council together with clinicians, managers and lay members from NHS Bath and North East Somerset Clinical Commissioning Group.

In March 2019, the Health and Care Board held its first meeting in public. At the meeting, the Board agreed its Terms of Reference as well as a Joint Working Framework, which

sets out aspirations around common goals and working practices together with legal and financial agreements in support of joint management and commissioning.

The Health and Care Board will normally meet at least twice a year to make decisions about the future of health and social care services in Bath & North East Somerset. It promotes collaboration between local council and NHS services by developing joint strategies and pooling financial resources to maximise value for money. The Board also monitors the impact of the Council and CCG's integrated commissioning arrangements on the health and wellbeing outcomes for our population.

Register of interests

We recognise that effective handling of conflicts of interest is crucial to give confidence to patients, tax payers, healthcare providers and Parliament that our commissioning decisions are robust, fair and transparent and offer value for money. In managing conflicts of interest, we follow Section 14O of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) ("the Act") which sets out the minimum requirements of what we must do in terms of managing conflicts of interest, and the NHSE statutory guidance *Managing conflicts of interest* (2017)[7].

Our *Standards of Business Conduct Policy*[8] complies with national guidance and sets out our expectations regarding standards of business conduct for the CCG, including the management of conflicts of interest. The Policy ensures that conflicts of interest are managed in a way that cannot undermine the probity and accountability of the organisation. The Policy also provides guidance to all member practices, staff and Governing Body members on the receipt of gifts and hospitality.

We maintain and regularly review a register of staff's declarations of interest. We publish a Register of our Board members' interests, and how we manage these, on our website, https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-%20governance/register-of-interests-2.

We also maintain and regularly review a register of gifts, hospitality and sponsorship, which is published on our website, https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/register-hospitality-gifts-sponsorship

Personal data related incidents

The CCG formally reported one personal data related incident to the Information Commissioner's Office during 2018/19.

The Information Commissioner's Office (ICO) considered the information we provided, and based on the information they recorded about the breach decided that no further action by the ICO was necessary on this occasion.

[7] Managing conflicts of interest: revised statutory guidance for CCGs 2017, https://www.england.nhs.uk/publication/managing-conflicts-of-interest-revised-statutory-guidance-for-ccgs-2017/

[8] https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/10478

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

Bath and North East Somerset CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement is published on our website: https://www.bathandnortheastsomersetccg.nhs.uk/assets/uploads/2017/04/Modern-Slavery-Act-2015-Statement.pdf

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 Executive Officer to be the Accountable Officer of Bath and 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 a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts 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 income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts; and,
- Prepare the accounts on a going concern basis; and
- Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the 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 Bath and North East Somerset CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Tracey Cox
Chief Executive Officer
23 May 2019

Governance Statement

Introduction and context

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

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

As at 1 April 2019, 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

We describe our governance arrangements and their effectiveness in the Members report, including information about:

- Key features of our constitution in relation to governance, including the split of responsibilities and decision making between our Membership Body and our Governing Body;
- Information about our Membership and our Governing Body, including key responsibilities, membership, attendance records and highlights of their work over the year;
- Information about our Membership Body's and our Governing Body's committees, including key responsibilities, membership, attendance records, and highlights of their work over the year;
- The performance of our Membership Body and Governing Body, including their own assessment of their effectiveness;

- Membership of the CCG's Audit Committee.

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, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk management arrangements and effectiveness

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

The 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.

Risk management strategy

Our risk management strategy was updated in 2018/19, as the previous version had come to the end of its two-year validity in March 2018. We publish our risk management strategy at https://www.bathandnortheastsomersetccg.nhs.uk/documents/policies-and-governance/risk-management-strategy

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 escalation.

The recent update to the strategy included the following main changes:

- inclusion of the risk management approach associated with Programme Management;
- an update of the ownership and authority section to say that Directors will own all corporate risks;
- inclusion of a section on strategic risk management through the Board Assurance Framework;
- an update to the escalation process to say that programmes may escalate risks to corporate register if their Senior Responsible Owner thinks it appropriate.

The Board Assurance Framework

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 BAF details:

- The key business objectives (for 2018/19, these were place-based services, transformation, securing sustainability and our approach to delivery.;
- 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.

We updated the format of our Board Assurance Framework (BAF) in 2017/18 with a new simplified structure. In 2018/19, the BAF had four overarching objectives:

- place-based services;
- transformation;
- securing sustainability; and
- our approach to delivery.

The BAF takes into account our risk appetite and outlines the systems in place to manage delivery of our strategic objectives, and to control the risks to those objectives. The BAF 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.
In November 2018 our internal auditors reported that our BAF provided “significant assurance” and that the BAF “strongly compares to best practice”. Specifically, the auditors stated that particularly strong aspects of the BAF include:

- Clear ownership of risks denoting those with the responsibility for managing the process of reducing or mitigating the risk to an acceptable level;
- Each risk is assigned a consistent score, and is documented in a clear and concise fashion;
- Each BAF risk is managed against a deadline, enhancing accountability for risk mediation;

- Separate analysis of gaps in the controls and relevant assurance relating to the controls for each risk; and
- An Individual risk appetite (mandated at Board level from the Risk Appetite Statement) is assigned to each risk, allowing management resource to be focused on risks furthest from their target level. 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. The BAF will be reviewed for 2019/20 but it is expected that many of the objectives and risks will continue into next year.

Embedding risk management in our activities, and stakeholder engagement
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 – this supports us in identifying, assessing and managing risks associated with commissioning decisions. The Performance Report contains for more information about how we use patient insight to improve health services, and how we seek to reduce health inequalities that exist across the region.

To ensure risk management is embedded in our operations and decision-making, staff use templates for business cases, procurement, and committee reports that clearly request that risk assessment and impact analysis are carried out as part of the work about which the paper reports and/or requests a decision by relevant governance bodies or individuals.

Staff engagement with risk
To support the implementation of the updated strategy and to improve our management of risk, we undertook risk management training for staff (targeting risk managers and owners) to improve competency in risk management. Attendees at each training workshop had the opportunity to provide feedback, and as a result further changes were made to the organisation's risk appetite which was ratified by the Board via a risk appetite statement in January 2019.

Capacity to Handle Risk

We have in place clear leadership and ownership of the risk management process, through effective governance structures and clearly described and allocated responsibilities of Directors and committees. 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. Committees receive timely and accurate information in advance of meetings to assess risks to compliance with the clinical commissioning group's statutory obligations.

The Audit Committee is responsible for regularly monitoring and reviewing the BAF. The Audit Committee scrutinises the BAF at each of its meetings, and provides robust challenge and key advice. In doing so, the Audit Committee takes into account internal and external auditors' reports. The Audit Committee's review of the BAF is regularly reported to the CCG Board, who regularly reviewed the BAF during 2018/19. The BAF and its

underpinning processes enable 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.

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.

Risk Assessment

The CCG uses its BAF and organisation-wide risk register as its key tools to identify, assess and manage risk.

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 BAF 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.

Our risk management process also extends to our main savings programmes within which separate risk registers are maintained and risks are managed at the programme level. All of our main programmes of work also undertake quality, equality and data protection impact assessments, the risks from which are also managed at programme level.

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 2018/19 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 been steady during 2018/19 with six high scoring risks on the corporate risk register in May and July 2018, then five in September and November 2018. This had reduced to 4 corporate risks by the end of the financial year in March 2019.

The risks discussed by the Board, the Audit Committee and the Joint Commissioning Committee have consistently included financial risks and QIPP delivery; adult mental health in patient capacity; delivery of the 4-hour waiting time target in A&E; and during the year, risks regarding commissioning at scale and the Integrated Care Alliance.

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.

Policy framework

We have in place a comprehensive framework of policies which govern and describe the ways in which we conduct our business, and clarify supporting arrangements. We regularly review and update our policies to ensure the CCG's compliance and adherence with relevant legislation, regulation, and national policy. The Audit Committee receives an annual policy review report which assures it that our policies are current and relevant. We publish all our policies internally, and externally as required.

The prime financial policies, appended to the Constitution, are part of the CCG's control environment for managing the CCG's financial affairs. These policies contribute to good corporate governance, internal control and the management of risk. They also enable sound administration, reduce the risk of irregularities and support the commissioning and delivery of effective, efficient and economical services.

Annual audit of conflicts of interest management

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) 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.

During December 2018 and January 2019, internal auditors KPMG reviewed our arrangements to manage conflicts within the CCG. The audit concluded that we have strong, established processes in place to manage conflicts of interest, and that we demonstrate compliance with the NHSE's conflicts of interest statutory guidance. The audit returned an assessment of 'significant assurance with minor improvement opportunities' which related to the format of our register of interests, and opportunity to administrate more efficiently, at BSW level, our staff Conflicts of Interest training records.

Data quality

To be an effective commissioner the CCG needs to use business intelligence effectively. This includes numerical information analysis, activity modelling, performance reporting, and increasingly, population level analytics. The successful application of business intelligence relies upon accurate and high quality data.

The CCG has developed a robust process for assuring data quality with its providers as part of its contractual mechanisms. Data quality issues are identified through a number of control mechanisms and tracked through to resolution through appropriate fora.

Our Council of Members and our Board are satisfied that the data and information we provide to them is comprehensive, current and adequate for the purposes of their business. We regularly seek the Board's and its committees' feedback on data and information, and review and update our process for assuring the quality of data and information accordingly, as appropriate.

As in previous years, the Audit Committee received (in July 2018) a data quality annual report and work plan for 2018/19.

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 called the Data Security and Protection Toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and have developed information governance processes and procedures in line with the Data Security and Protection Toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities – this handbook is available to all staff on our intranet, clearly signposted to any new starters, and regularly reviewed as part of our rolling programme of policy reviews.

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

We received assurance as to our Data Security and Protection Toolkit submission through the oversight of our information governance steering group comprising our Caldicott Guardian, Senior Information Risk Owner, Data Protection Officer, Chief Information Officer and Information Governance Manager. 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.

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

As per our Month 9 Governance Statement, the control issues currently facing the CCG are as follows:

Control issue	Mitigating actions in place
Quality and Performance - Other	Diagnostics Testing - activity being outsourced where possible so actions in place in addition to review at Contract meetings
Quality and Performance - RTT/52 week wait	CCG will continue to manage RUH against their Remedial Action Plans at the monthly Contract Review Meetings
Quality and Performance - Accident and Emergency	CCG will continue to manage RUH against their Remedial Action Plans at the monthly Contract Review Meetings (i.e. 4 hour)

Review of economy, efficiency and 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.

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 not delegated any of its statutory 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, I, Information Governance, IT Technology and Support, IT Programmes and Planning, Data Services management, GP Information Technology.

Counter fraud arrangements

A system of counter fraud has been in operation throughout 2018/19. 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 CCG has an accredited Local Counter Fraud Specialist who produces and delivers a risk based work plan for the year, addressing each area of the Standards for Commissioners. This is agreed with the Chief Financial Officer, who has executive responsibility for tackling fraud, bribery and corruption, and approved by the Audit Committee. Progress against the work plan and any key issues arising from the work are reported to the Audit Committee through regular progress reports and an annual report, with regular information and planning meetings taking place with the Chief Financial Officer and other officers. There is proactive response to NHS Protect quality assurance recommendations and other good practice recommendations including those arising from local proactive and investigative work.

Head of Internal Audit Opinion

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

Basis of opinion for the period 1 April 2018 to 31 March 2019

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 Trust'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 its 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 Trust. The opinion is 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 aspects of the risk and 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 2018 to 31 March 2019 is that:

'Significant assurance with minor improvements required' 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 2018 to 31 March 2019 inclusive, and is based on the nine audits that we completed during 2018/19.

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 28 March 2019.

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 2018/19 assignments. For the remaining reviews completed we issued five ‘significant’ assurance ratings and four ‘significant assurance with minor improvement opportunities’ ratings. Our audits have 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
13 May 2019

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

Area of Audit	**Level of Assurance Given**
Conflicts of interest	Significant assurance with minor improvement opportunities
Financial Systems	Significant assurance with minor improvement opportunities
Financial reporting	Significant assurance
Risk management and BAF	Significant assurance
Delegated commissioning	Significant assurance
Integrated Commissioning	Significant assurance with minor improvement opportunities
Effectiveness of QIPP Programme	Significant assurance
Business Continuity	Significant assurance
GDPR	Significant assurance with minor improvement opportunities

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 been advised on the implications of the result of this review by:

- The Board
- The Audit Committee
- Internal audit

I have reviewed the work of the Board and the Audit Committee 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. 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.

Corporate Governance Report

Appendix 1 – Memberships of the BaNES CCG's Primary Care Commissioning Committee, Joint Commissioning Committee, Quality Committee and Finance and Performance Committee during 2018/19

Primary Care Commissioning Committee

Members	
Suzannah Power	Lay Member (patient and public involvement) and Committee Chair
Katie Hall	Lay Member (quality)
John Holden	Lay Member (audit and governance)
Corinne Edwards	Interim COO (*from September 2018*) Director of Acute & Primary Care Commissioning (*till August 2018*)
Sarah James	Chief Financial Officer
Lisa Harvey	Director of Nursing and Quality
Dr Ruth Grabham	GP Board member
John Moon	Practice representative Board member
In Attendance (no voting rights)	
Debra Elliot	Director of Commissioning, South Central Sub Region NHSE
Dean Walton	Finance Manager, South Central Sub Region NHSE
Dr Gareth Bryant	LMC representative
Alex Francis	Healthwatch representative
Cllr Vic Pritchard	Health & Wellbeing Board representative
Dr Becky Reynolds	Public Health representative
James Childs-Evans	Senior Commissioning Manager (Primary Care), BaNES CCG
John Ridler	Deputy Chief Finance Officer, BaNES CCG

Joint Commissioning Committee

BaNES CCG Members	
Tracey Cox	Chief Executive Officer, Committee Co-Chair*
Sarah James	Chief Financial Officer
Dr Ruth Grabham	Medical Director
Lisa Harvey	Director of Nursing & Quality
Corinne Edwards	Interim COO (*from September 2018*) Director of Acute & Primary Care Commissioning (*till August 2018*)
Catherine Phillips	Acting Director of Acute Commissioning (*from September 2018*)
B&NES Council Members	
Mike Bowden	Corporate Director, Committee Co-Chair*
Jane Shayler	Director, Integrated Health & Care Commissioning, BaNES CCG & B&NES Council
Caroline Holmes (*from January 2019*)	Acting Director, Integrated Health & Care Commissioning BaNES CCG & B&NES Council
Dr Bruce Laurence	Director of Public Health
Tammy Randall *(till January 2019)*	Finance Manager, People & Communities, B&NES Council
Liz Beazer (*from February 2019)*	Finance Manager, People & Communities, B&NES Council
BaNES Clinical Members (voting rights for clinical agenda items)	
Dr Tim Sephton	GP Board Member, CCG
Dr Elizabeth Hersch	GP Board Member, CCG
Dr Daisy Curling	GP Board Member, CCG
Dr Bryn Bird *(from August 2018)*	GP Board Member, CCG
John Moon	Practice Manager Board Member, CCG

*The Joint Commissioning Committee Terms of Reference stipulate that the CCG's CEO and the Council's Corporate Director co-chair the Committee.

Quality Committee

Members	
Katie Hall	Lay Member (Quality), Committee Chair
Lisa Harvey	Director of Nursing & Quality / Registered Nurse
Dr Ruth Grabham	Medical Director
Dr Daisy Curling	GP Board Member
Tracey Cox	Chief Executive Officer
Suzannah Power	Lay Member (Patient and Public Engagement)
Becky Reynolds	Public Health Representative
Roger Tipping	Healthwatch Representative

Finance and Performance Committee

Members	
Dr Ian Orpen	Clinical Chair, Committee Chair
Tracey Cox	Chief Executive Officer
Sarah James	Chief Financial Officer
Dr Ruth Grabham	Medical Director
Lisa Harvey	Director of Nursing & Quality
John Holden	Lay Member (Audit & Governance)
Corinne Edwards	Director of Acute and Primary Care Commissioning/COO
Julie-Anne Wales	Head of Corporate Governance & Planning
Jane Shayler	Director, Integrated Health & Care Commissioning, BaNES CCG & B&NES Council
Caroline Holmes (*from January 2019*)	Acting Director, Integrated Health & Care Commissioning BaNES CCG & B&NES Council

Remuneration and Staff Report

Remuneration Report

The remuneration and staff report sets out the CCG's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers.

Remuneration Committee

Please see details of the Remuneration Committee in the Director's Report on page 66.

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) 2018/19

Name and title[3] [4]	From[1]	To	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) to nearest £100 [6]	(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	01/04/2018	Present	90-95	200	0	0	0-2.5	90-95
Dr Ruth Grabham, Medical Director	01/04/2018	Present	85-90	0	0	0	(2.5)-(5)	80-85
Tracey Cox, Chief Officer [2]	01/04/2018	Present	70-75[2]	200	0	0	190-192.5	265-270
Sarah James, Chief Financial Officer	01/04/2018	Present	95-100	200	0	0	67.5-70	165-170
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member	01/04/2018	Present	80-85	100	0	0	22.5-25	105-110
Corinne Edwards, Interim Chief Operating Officer	01/09/2018	Present	55-60	100	0	0	50-52.5	110-115
Dr Elizabeth Hersch, GP Cluster Lead	01/04/2018	Present	25-30	100	0	0	(0)-(2.5)	25-30
Dr Daisy Curling, GP Cluster Lead	01/04/2018	Present	25-30	0	0	0	(0)-(2.5)	25-30
Dr Timothy Sephton, GP Cluster Lead	01/04/2018	Present	25-30	0	0	0	2.5-5	30-35
Dr Brynn Bird, GP Cluster Lead	01/08/2018	Present	15-20	0	0	0	10-12.5	25-30
John Moon, Practice Manager Representative	01/04/2018	Present	10-15	0	0	0	0	10-15
Katie Hall, Lay Member for Quality	01/04/2018	Present	5-10	0	0	0	N/A	5-10
John Holden, Lay Member for Audit and Governance [5]	01/04/2018	Present	15-20	0	0	0	N/A	15-20
Suzannah Power, Lay Member for Patient and Public Involvement	01/04/2018	Present	15-20	100	0	0	N/A	15-20

Notes:

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

*2. The salary figures shown for Tracey Cox (Chief Officer) exclude recharges made to: (I) BSW Sustainability & Transformation Partnership (STP) for Interim Senior Responsible Officer role held since August 2018; and (iI) NHS Swindon and NHS Wiltshire CCG's as part of the Banes, Swindon & Wiltshire (BSW) Chief Executive shared role held since 1st March 2019. The total salary across **all** organisations for the year was in the salary band of 120k-125k.*

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

4. 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

5. John Moon was not a member of the NHS Pension scheme during the financial year

6. 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 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.

Pension Disclosure – 2018/19

NHS Bath & North East Somerset Clinical Commissioning Group

Pensions Disclosure - 2018-19 - AUDITED:

Name and title[1] [2]	(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 2019 (bands of £5,000)	(d) Lump sum at pension age related to accrued pension at 31st March 2019 (bands of £5,000)	(e) Cash Equivalent Transfer Value at 1 April 2018	(f) Real increase in Cash Equivalent Transfer Value[4]	(g) Cash Equivalent Transfer Value at 31 March 2019[3]	(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	35-40	250	0	257	Nil
Dr Ruth Grabham, Medical Director	0-2.5	0-2.5	20-25	60-65	426	40	491	Nil
Tracey Cox, Chief Officer	7.5-10	20-22.5	50-55	125-130	671	241	950	Nil
Sarah James, Chief Financial Officer	2.5-5	5-7.5	35-40	100-105	601	125	755	Nil
Lisa Harvey, Director of Nursing & Quality; Registered Nurse Member	0-2.5	2.5-5	20-25	65-70	384	67	473	Nil
Corinne Edwards, Interim Chief Operating Officer	2.5-5	2.5-5	30-35	70-75	425	72	575	Nil
Dr Elizabeth Hersch, GP Cluster Lead	0-2.5	0-(2.5)	10-15	20-25	152	18	178	Nil
Dr Daisy Curling, GP Cluster Lead	0-2.5	0-(2.5)	10-15	30-35	164	25	198	Nil
Dr Timothy Sephton, GP Cluster Lead	0-2.5	0-(2.5)	0-5	5-10	40	6	51	Nil
Dr Brynn Bird, GP Cluster Lead	0-2.5	0-2.5	10-15	0-5	90	23	117	Nil

Notes:

1. 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.

2. The figures for Dr Ian Orpen, Dr Ruth Grabham, Dr Elizabeth Hersch, Dr Daisy Curling, Dr Timothy Sephton and Dr Brynn Bird 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).

3. 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 members 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.

4. 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).

For comparison the table below shows pensions for senior managers for 2017/18 – Audited

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).

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 2018/19 due to ill health.

Payments to past members

During 2018/19 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 Multiple 2018/19 – 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 2018/19 was £90,000 - £95,000 (2017/18: £90,000 - £95,000). Based on a whole time equivalent, this salary was in the band of £150,000 - £155,000 (2017/18: £150,000 - £155,000). This was 3.49 (2017/18: 3.51) times

the median remuneration of the remainder of the workforce, which was £43,682 (2017/18: £43,469).

In 2018/19, 1 (2017/18: 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 (2017/18: £155,000 - £160,000). This relates to a clinical employee working one session per week at an actual cost in the band £15,000 - £20,000 (2017/18: £15,000 - £20,000).

Full-time equivalent remuneration ranged from £18,000 to £157,000 (2017/18: £18,000 to £156,000).

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 Report

Number of senior managers
The CCG defines a senior manager as a person in a senior position who has authority or responsibility for directing or controlling major activities within the CCG. This means those who
influence the decisions of the CCG as a whole rather than the decisions of individual parts of the
organisation.

As at 31 March 2019, the number of senior managers by Agenda for Change band was:

Agenda for Change Band	Number of senior managers
Very Senior manager	6 (inclusive of 2 STP roles)
Band 9	1 (STP role)

Staff numbers and costs

Recoveries in respect of employee benefits	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(444)**	**(26)**	**(469)**	**(471)**
Social security costs	**(49)**	**-**	**(49)**	**(45)**
Employer contributions to the NHS Pension Scheme	**(88)**	**-**	**(88)**	**(46)**
Total recoveries in respect of employee benefits	(581)	(26)	(607)	(562)

The increase in costs and associated recoveries of employee benefits is mostly associated with the CCG recharge of pay costs

Employee benefits and staff numbers

Employee benefits	**Admin**			**Programme**			**Total**		**2018-19**
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	2,279	203	**2,483**	1,344	139	**1,483**	3,623	342	**3,965**
Social security costs	252	-	**252**	140	0	**141**	392	0	**393**
Employer contributions to the NHS Pension Scheme	310	-	**310**	236	(0)	**236**	546	(0)	**546**
Other pension costs	0	-	**0**	1	-	**1**	1	-	**1**
Apprenticeship Levy	3	-	**3**	(0)	-	**(0)**	3	-	**3**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	4	-	**4**	-	-	**-**	4	-	**4**
Gross employee benefits expenditure	**2,848**	**203**	**3,052**	**1,722**	**139**	**1,860**	**4,570**	**342**	**4,912**
Less recoveries in respect of employee benefits (note 4.1.2)	(420)	-	**(420)**	(161)	(26)	**(186)**	(581)	(26)	**(607)**
Total - Net admin employee benefits including capitalised costs	**2,428**	**203**	**2,632**	**1,561**	**113**	**1,674**	**3,989**	**316**	**4,306**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,428**	**203**	**2,632**	**1,561**	**113**	**1,674**	**3,989**	**316**	**4,306**

Employee benefits	**Admin**			**Programme**			**Total**		**2017-18**
	Permanent Employees £'000	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**	**Permanent Employees £'000**	**Other £'000**	**Total £'000**
Employee Benefits									
Salaries and wages	2,096	117	**2,213**	895	173	**1,068**	2,991	290	**3,280**
Social security costs	231	9	**240**	95	3	**97**	325	12	**338**
Employer contributions to the NHS Pension Scheme	278	11	**289**	121	2	**123**	399	13	**412**
Other pension costs	0	-	**0**	0	-	**0**	0	-	**0**
Apprenticeship Levy	1	-		-	-				
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	-	-	**-**	-	-	**-**	-	-	**-**
Gross employee benefits expenditure	**2,606**	**137**	**2,742**	**1,110**	**177**	**1,287**	**3,715**	**315**	**4,030**
Less recoveries in respect of employee benefits (note 4.1.2)	(347)	-	**(347)**	(134)	(82)	**(216)**	(480)	(82)	**(562)**
Total - Net admin employee benefits including capitalised costs	**2,259**	**137**	**2,396**	**976**	**95**	**1,072**	**3,235**	**233**	**3,468**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	**2,259**	**137**	**2,396**	**976**	**95**	**1,072**	**3,235**	**233**	**3,468**

Staff composition

The figures presented in Table 1 below exclude non-executive directors / lay Governing Body Members but include executive board members / Governing Body Members.

Table 1: Number and status of staff as at 31 March 2019

Assignment Status	**Headcount**	**FTE**
Active Assignment	101	76.95
• of which permanently employed:	59	51.7
• of which 'other'*	42	25.25
Internal Secondment	3	2.75
Maternity & Adoption	5	4.6
Out on External Secondment - Paid	0	0
Grand Total	109	84.3

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 31 March 2019, there are 8 staff (7.67 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 2018/19 was hosted by Great Western Hospitals NHS Foundation Trust, for a number of their staff.

* members of staff with a permanent (UK) employment contract directly with the CCG
** staff engaged on the objectives of the CCG that does not have a permanent (UK) employment contract with the entity, including short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities where the whole or majority of the employees' costs are met locally

The figures presented in Table 2 below offers an analysis of the number of persons of each sex who were directors, senior managers and employees of the company.

Table 2: Staff by gender

	Female (Headcount)	Male (Headcount)
Very Senior Managers	4	2
Senior Managers Band 8c – 9 plus Clinical leads, GP's and Lay Members	19	10
Employees bands 3 to 8b	64	10

Sickness absence data

	2018/19 numbers	2017/18 numbers
Total days lost	439	163
Total staff	99	63
Average working days lost	4.43	3

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/workforce equality

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.

All our staff policies are accessible to our staff via our intranet.

Other employee matters

<u>The Trade Union (Facility Time Publication Requirements) – Regulations 2017</u>

The CCG confirms that there are no relevant union officials who are staff members of the CCG. No employee of the CCG takes time off during their working hours for the purpose of taking part in any activities in relation to which they are acting as a representative of a union.

<u>Staff Consultation</u>

BaNES CCG has undertaken three consultation exercises during 2018/19. The first one was in relation to the collaboration between NHS Bath and North East Somerset Clinical Commissioning Group (CCG) and Bath & North East Somerset Council. In November

2018 the CCG Board and Council Cabinet agreed to strengthen the existing integrated commissioning arrangements as a natural next step in the development of the current joint working arrangements. The consultation proposed to create further joint working through a set of structural changes. These changes represented the first step on the journey of the two organisations towards a fully integrated structure which aligns teams and processes around shared strategic priorities.

The second consultation began the process to align BaNES, Swindon and Wiltshire (BSW) CCG's by consulting on the appointment of a single Accountable Officer across the three CCG's. The consultation took place in November 2018, and the Accountable Officer was appointed in March 2019.

The third consultation continues the process of creating an aligned BSW CCG and is consulting on the five Executive Director posts across BSW. The consultation began on 26 March 2019 and is still live at the time of writing.

Staff Survey

The staff survey ran from 20 June 2018 – 27 July 2018, 59 staff took part. Employees of the CCG are generally positive about their experience of working with the CCG, evidenced by some of the top scoring results:

- 62% of staff believe that their team works effectively with other teams in the CCG.
- 83% of staff agree or strongly agree that there are frequent opportunities for them to show initiative in their role.
- 55% of staff receive regular and constructive feedback on their performance.
- 53% of staff have confidence in the leadership of the CCG to deliver their plans and priorities.
- 61% of staff believe the CCG focuses on continually improving the quality of services.
- 55% of staff look forward to going to work.

Expenditure on consultancy

For 2018/19 the spend on Consultancy services (Note 5 of the Annual Accounts) is £12k (2017/18 £12k), which includes £2k of VAT consultancy services (2017/18 £8k), £7k on consultancy services associated with Human Resources and Organisational Development and £3k on the CCG's share of costs associated with an independent review of the Local Safeguarding Children's Board (LSCB) for Avon and Somerset.

The CCG's external auditor, Grant Thornton, were paid £43k (including VAT) for Audit Services in the reporting year 2018/19 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.

The CCG has also accrued an additional £10k in respect of a separate, nationally-mandated audit of mental health expenditure.

Off Payroll Engagements –Audited

Table 1:

For all off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as at 31 March 2019	1
Of which, the number that have existed:	
For less than one year at the time of reporting	1
For between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

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

Table 2:

For all new off-payroll engagements between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	1
Of which….	
Number assessed as caught by IR35	0
Number assessed as NOT caught by IR35	1
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:

For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

Number of off-payroll engagements of board member, and / or senior officers with significant financial responsibility, during the financial year.	0
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.	14

Exit packages, including special (non-contractual) payments

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	1	3,871	1	3,871
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**3,871**	**1**	**3,871**

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

[1]Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	3,871	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**3,871**	**-**	**-**

[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 - £0 for 2018/19.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change used for redundancies.

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.

Parliamentary Accountability and Audit Report

Bath and North East Somerset Clinical Commissioning Group is not required to produce a Parliamentary Accountability and Audit Report but has opted to include disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges in this Accountability Report as part of the Financial Review, p.52. An audit certificate and report is also included in this Annual Report at page 103.

Independent auditor's report to the members of the Governing Body of NHS Bath and North East Somerset CCG

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Bath and North East Somerset (the 'CCG') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, 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 International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2019 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 2018-19; 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.

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, 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 audit 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 the 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 Corporate 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 Corporate 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 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 2018-19 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or

- we make 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 set out on pages 70 to 71, 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 they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

The Board is Those Charged with Governance. Those charged with governance are responsible for overseeing the CCG’s financial reporting process.

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 2019.

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

Responsibilities of the Accountable Officer

As explained in the Corporate 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(1)(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 2019, 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 and North East Somerset CCG in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Use of our report

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.

Julie Masci

Julie Masci, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Bristol

ANNUAL ACCOUNTS

Tracey Cox
Chief Executive Officer
23 May 2019

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services[1]	3	(2,831)	(1,041)
Other operating income[1]	3	(5)	(199)
Total operating income		**(2,836)**	**(1,240)**
Staff costs	4	4,912	4,031
Purchase of goods and services	5	269,071	255,746
Depreciation and impairment charges	5	4	-
Provision expense	5	205	(411)
Other Operating Expenditure[2]	5	136	202
Total operating expenditure		**274,328**	**259,568**
Net Operating Expenditure		**271,492**	**258,327**
Finance expense		0	-
Net expenditure for the year		**271,492**	**258,327**
Total Net Expenditure for the Financial Year		**271,492**	**258,327**
Comprehensive Expenditure for the year ended 31 March 2019		**271,492**	**258,327**

[1] The prior year figures (2017-18) have been restated as there has been re-categorisation of income from Other operating income to be included in Income from sales of goods and services.

[2] Other operating expenditure consists of Chair and Non-executive costs (£132k) and Clinical Negligence costs (£4k)
2017-18 prior year included Chair and Non-executive costs (£148k), Clinical negligence costs (£4k) and Software Development costs (£50k)

The notes on pages 114-150 form part of this statement

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	11	34	20
Total non-current assets		34	20
Current assets:			
Trade and other receivables	12	1,727	1,467
Cash and cash equivalents	13	1	78
Total current assets		**1,728**	1,545
Total current assets		**1,728**	1,545
Total assets		**1,761**	1,565
Current liabilities			
Trade and other payables	14	(20,723)	(14,622)
Provisions	16	(205)	-
Total current liabilities		**(20,928)**	(14,622)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(19,167)**	(13,056)
Total non-current liabilities		-	-
Assets less Liabilities		**(19,167)**	(13,056)
Financed by Taxpayers' Equity			
General fund		(19,167)	(13,056)
Total taxpayers' equity:		**(19,167)**	(13,056)

The notes on pages 114-150 form part of this statement

The financial statements on pages 110-113 were approved by the Governing Body on 23rd May 2019 and signed on its behalf by:

Sarah James
Chief Financial Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2019

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(13,056)	0	0	**(13,056)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(271,492)	0	0	**(271,492)**
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(271,492)**	**0**	**0**	**(271,492)**
Net funding	265,382	0	0	265,382
Balance at 31 March 2019	**(19,167)**	**0**	**0**	**(19,167)**

	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	**(13,056)**	**0**	**0**	**(13,056)**

The notes on pages 114-150 form part of this statement

Statement of Cash Flows for the year ended 31 March 2019

	Note	**2018-19 £'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(271,492)	(258,325)
Depreciation and amortisation	5	4	0
Impairments and reversals	5	0	0
Finance Costs		0	0
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	12	(260)	(31)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	14	6,101	2,254
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	16	0	0
Increase/(decrease) in provisions	16	205	(411)
Net Cash Inflow (Outflow) from Operating Activities		**(265,441)**	(256,512)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(18)	(20)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(18)**	(20)
Net Cash Inflow (Outflow) before Financing		**(265,459)**	(256,533)
Cash Flows from Financing Activities			
Parliamentary Funding Received		265,382	256,442
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**265,382**	256,442
Net Increase (Decrease) in Cash & Cash Equivalents	13	**(77)**	(91)
Cash & Cash Equivalents at the Beginning of the Financial Year		**78**	169
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		**1**	78

The notes on pages 114-150 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 2018-19 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 a 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 Childrens 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. Note 20 to the accounts provides details of the income and expenditure.

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**

The Clinical Commissioning Group in acting as a host of the BaNES, Swindon and Wiltshire Strategic Transformation Partnership under an agency type arrangement have applied critical judgement in applying the necessary accounting treatment for this. This is in line with the requirements of IFRS 10 and IFRS 11 and the treatment has been to exclude all transactions relating to the host arrangement as joint control does not exist and therefore net accounting has been applied.

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. The monthly average variability across the year for 2018/19 of prescribing spend was in the region of 5% but this does not lead to material impact in terms of financial value.

1.5 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. However, the clinical commissioning group has had no material impact arising due to IFRS 15 and there were no required adjustments to opening brought forward balances due to IFRS 15.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

- As per paragraph 121 of the Standard the clinical commissioning group will not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less,
- The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

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

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. Where income is received for a specific performance obligation that is to be satisfied 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, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

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

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.6.3 Local Government Pensions

The clinical commissioning group does not have any members of the Local Government Pension Scheme.

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.

1.8 Grants Payable

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.9 Property, Plant & Equipment

1.9.1 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.

1.9.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

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

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

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

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

1.9.3 **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.

1.10 **Intangible Assets**

1.10.1 **Recognition**

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

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

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

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

1.10.2 **Measurement**

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

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

1.11 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated. Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective

basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.12 **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.

1.12.1 **The Clinical Commissioning Group as Lessee**

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

1.12.2 **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.

1.13 **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.

1.14 **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:

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

- A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

- A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

- A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

- A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **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 clinical commissioning group. Currently the Clinical Commissioning Group has no clinical negligence claims outstanding.

1.16 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS 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.

1.17 **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 each year to a pooled fund, which is used to settle the claims.

1.18 **Carbon Reduction Commitment Scheme**

The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The clinical commissioning group is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.19 **Contingent liabilities and contingent assets**

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, contingent liabilities and contingent assets are disclosed at their present value.

1.20 **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.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.21 **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 2018-19 accounts which have been recognised at historic cost.

1.22 **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.

1.23 **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.

1.24 **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).

1.25 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

2 Financial Performance Targets

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

Bath and North East Somerset Clinical Commissioning Groups performance against those duties was as follows:

	2018-19 Target	2018-19 Performance
Expenditure not to exceed income[1]	274,367	274,328
Capital resource use does not exceed the amount specified in Directions	18	18
Revenue resource use does not exceed the amount specified in Directions	271,531	271,492
Revenue administration resource use does not exceed the amount specified in Directions	4,282	4,282

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

NHS England set the Clinical Commissioning Group a Revenue Resource Limit of £271,531,000 for 2018-19, and the Clinical Commissioning Group achieved an underspend of £39,000 against this target. The Clinical Commissioning Group spent in full its administration costs budget of no more than £4,282,000.

	2017-18 Target	2017-18 Performance
Expenditure not to exceed income	261,063	259,585
Capital resource use does not exceed the amount specified in Directions	20	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

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, National Prescribing Rebate of £232,000 and local surplus of £99,000. 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.

3 Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**0**	50
Non-patient care services to other bodies[1]	**2,170**	428
Income generation	**-**	-
Other Contract income	**55**	-
Recoveries in respect of employee benefits	**607**	563
Total Income from sale of goods and services	**2,831**	**1,041**
Other operating revenue		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	2
Charitable and other contributions to revenue expenditure: non-NHS[2]	**5**	-
Other non contract revenue[3]	**-**	197
Total Other operating revenue	**5**	**199**
Total Operating Revenue	**2,836**	**1,240**

[1]The relates to an increase in the monies for BSW wide projects including digital transformation being allocated to Wiltshire or Swindon CCGs and a share transferred to BaNES CCG. There was also funding received for the Transforming Care Partnership (TCP).

[2] This relates to a charitable donation received for the Macmillan GP.

[3] There have been some reclassifications of expenditure for 2018-19.

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	-	1,855	1	607
Non NHS	-	315	54	-
Total	**-**	**2,170**	**55**	**607**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	-	2,170	55	607
Over time	-	-	-	-
Total	**-**	**2,170**	**55**	**607**

3.2 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date

	2018-19 Total	Revenue expected from NHSE Bodies	Revenue expected from Other DHSC Group Bodies	Revenue expected from Non-DHSC Group Bodies
	£000s	£000s	£000s	£000s
Not later than 1 year	-	-	-	-
Later than 1 year, not later than 5 years	-	-	-	-
Later than 5 Years	-	-	-	-
Total	**-**	**-**	**-**	**-**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

Total **2018-19**

	Permanent Employees	Other	Total
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	**3,623**	**342**	**3,965**
Social security costs	**392**	**0**	**393**
Employer Contributions to NHS Pension scheme	**546**	**0**	**546**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**3**	**-**	**3**
Termination benefits	**4**	**-**	**4**
Gross employee benefits expenditure	4,570	342	4,912
Less recoveries in respect of employee benefits (note 4.1.2)	**(581)**	**(26)**	**(607)**
Total - Net admin employee benefits including capitalised costs	3,989	317	4,306
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	3,989	317	4,306

4.1.1 Employee benefits **Total** **2017-18**

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**2,991**	**290**	**3,280**
Social security costs	**325**	**12**	**338**
Employer Contributions to NHS Pension scheme	**399**	**13**	**412**
Other pension costs	**0**	**-**	**0**
Apprenticeship Levy	**1**	**-**	**1**
Gross employee benefits expenditure	3,716	315	4,031
Less recoveries in respect of employee benefits (note 4.1.2)	**(480)**	**(82)**	**(562)**
Total - Net admin employee benefits including capitalised costs	3,236	233	3,468
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	3,236	233	3,468

4.1.2 Recoveries in respect of employee benefits **2018-19** **2017-18**

	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(444)**	**(26)**	**(469)**	**(471)**
Social security costs	**(49)**	**-**	**(49)**	**(45)**
Employer contributions to the NHS Pension Scheme	**(88)**	**-**	**(88)**	**(46)**
Total recoveries in respect of employee benefits	(581)	(26)	(607)	(562)

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**
Total	**69**	**8**	**77**	**63**	**4**	**68**

Of the above:
There are no people engaged on capital projects in either 2018-19 or 2017-18

4.3 Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		**2018-19 Other agreed departures**		**2018-19 Total**	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	1	3,871	1	3,871
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**1**	**3,871**	**1**	**3,871**

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

[1]Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	**£**	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	3,871	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**1**	**3,871**	**-**	**-**

[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 - £0 for 2018/19.

Redundancy and other departure costs have been paid in accordance with the provisions of Agenda for Change used for redundancies.

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.

4.4 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, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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 schemes is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the 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:

4.4.1 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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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.

4.4.2 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December

2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers' contributions of £505,156 were payable to the NHS Pensions Scheme (2017-18: £398,856) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. These costs are included in the NHS pension line of Note 4.

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	1,969	1,548
Services from foundation trusts[1]	114,877	105,168
Services from other NHS trusts	24,403	23,574
Services from Other WGA bodies	224	184
Purchase of healthcare from non-NHS bodies	70,437	70,292
Purchase of social care[2]	-	102
Prescribing costs	24,435	24,880
Pharmaceutical services	5	12
General Ophthalmic services	1	5
GPMS/APMS and PCTMS[3]	29,605	27,001
Supplies and services – clinical	1,314	1,235
Supplies and services – general	490	494
Consultancy services	12	12
Establishment[4]	836	557
Transport	5	4
Premises[5]	204	372
Audit fees[6]	43	43
Other non-statutory audit expenditure:		
· Other services[7]	10	-
Other professional fees[8]	53	70
Legal fees	2	15
Education, training and conferences	148	178
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**269,073**	**255,746**
Depreciation and impairment charges		
Depreciation [9]	4	-
Total Depreciation and impairment charges	**4**	**-**
Provision expense		
Provisions	205	(411)
Total Provision expense	**205**	**(411)**
Other Operating Expenditure		
Chair and Non Executive Members	131	148
Clinical negligence	4	4
Research and development (excluding staff costs)	1	50
Other expenditure	-	-
Total Other Operating Expenditure	**136**	**202**
Total Operating expenditure	**269,419**	**255,537**

[1] This relates to increased expenditure for acute hospital contracts, most notably the RUH NHS Foundation Trust including the Urgent Treatment Centre which is new contract expenditure this year with the Trust

[2] This related to a non-weight bearing pilot initiative that was only for the 2017-18 year

[3] The increase relates to contract uplifts awarded for the year

[4] This partly relates to increased merger costs in the year from practice mergers

[5] The reduction relates to a credit received for void space of property

[6] 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.

[7] The other audit services relates to expected costs for the audit of the Mental Health Investment Standard (MHIS) for the year.

[8] Internal Audit fees of £35k are included in this spend.

[9] The Depreciation relates to the non-current equipment assets held on the balance sheet.

6. Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	5,641	104,336	4,900	102,542
Total Non-NHS Trade Invoices paid within target	5,561	103,619	4,834	101,826
Percentage of Non-NHS Trade invoices paid within target	**98.58%**	**99.31%**	**98.65%**	**99.30%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,882	139,837	2,845	129,786
Total NHS Trade Invoices Paid within target	2,860	139,726	2,824	129,760
Percentage of NHS Trade Invoices paid within target	**99.24%**	**99.92%**	**99.26%**	**99.98%**

7. The Late Payment of Commercial Debts (Interest) Act 1998

	2018-19 £'000	2017-18 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

8. Investment revenue

	2018-19 £'000	2017-18 £'000
Interest Revenue		
Bank interest	-	-
Total interest revenue	**-**	**-**
Total investment revenue	**-**	**-**

9. Finance costs

	2018-19	2017-18
	£'000	£'000
Interest on late payment of commercial debt	-	-
Other interest expense	0	-
Total interest	**0**	**-**
Other finance costs	-	-
Total finance costs	**0**	**-**

10. Operating Leases

10.1 As lessee

The Clinical Commissioning Group occupies and pays rent on its office accommodation at St Martins Hospital. 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 IFRIC4 these arrangements are a lease and as such are accounted for in accordance with IAS 17. Payments in respect of this arrangement for 2018-19 are disclosed below:

10.1.1 Payments recognised as an Expense

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	97	1	**98**	-	190	2	**192**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**97**	**1**	**98**	**-**	**190**	**2**	**192**

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.

10.1.2 Future minimum lease payments

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	-	-	1	**1**	-	-	1	**1**
Between one and five years	-	-	2	**2**	-	-	3	**3**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**3**	**3**	**-**	**-**	**4**	**4**

10.2 As lessor

10.2.1 Rental revenue	**2018-19 £'000**	2017-18 **£'000**
Recognised as income		
Rent	-	2
Contingent rents	-	0
Total	**-**	**2**

10.2.2 Future minimum rental value	**2018-19 £'000 NHSE Bodies**	**2018-19 £'000 Other DHSC Group Bodies**	**2018-19 £'000 Non DH Group Bodies**	2017-18 **£'000 DH Group Bodies**	2017-18 **£'000 Non DH Group Bodies**
Receivable:					
No later than one year	-	-	-	-	1
Between one and five years	-	-	-	-	3
After five years	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**4**

11. Property, plant and equipment

2018-19	Information technology £'000	Total £'000
Cost or valuation at 01 April 2018	20	20
Addition of assets under construction and payments on account		-
Additions purchased	18	18
Cost/Valuation at 31 March 2019	**38**	**38**
Depreciation 01 April 2018	-	-
Charged during the year	4	4
Cumulative depreciation adjustment following revaluation	-	-
Depreciation at 31 March 2019	**4**	**4**
Net Book Value at 31 March 2019	**34**	**34**
Purchased	34	34
Government Granted	-	-
Total at 31 March 2019	**34**	**34**
Asset financing:		
Owned	34	34
Held on finance lease	-	-
Total at 31 March 2019	**34**	**34**

11.1 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Information technology	0	5

12 Trade and other receivables[1]	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue[2]	487	-	98	-
NHS prepayments	613	-	548	-
NHS accrued income	83	-	22	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	82	-	67	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments[3]	294	-	465	-
Non-NHS and Other WGA accrued income	93	-	80	-
VAT	74	-	28	-
Operating lease receivables	-	-	-	-
Other receivables and accruals[4]	1	-	159	-
Total Trade & other receivables	**1,727**	**-**	**1,467**	**-**
Total current and non current	**1,727**		**1,467**	

[1]There are no prepaid pension contributions in the receivables figures.

[2] This increase relates to a recharge to another CCG for prescribing costs and charges made to NHS England for Flu Vaccines

[3] This reduction relates to BaNES accruals for credit notes in 2017-18 and rent prepayments also being accrued in 2017-18

[4] This reduction relates to 2017-18 receivables being higher for STP monies due to us and for underperformance of independent provider contracts

12.1 Receivables past their due date but not impaired[1]

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	457	25	86	22
By three to six months	-	-	9	-
By more than six months[2]	-	-	135	-
Total	**457**	**25**	**230**	**22**

[1] The Clinical Commissioning Group does not hold any collateral against outstanding receivables at 31 March 2019.

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

12.2 Impact of Application of IFRS 9 on financial assets at 1 April 2018

	Cash and cash Equivalents	Trade and other receivables - NHSE bodies	Trade and other receivables - external	Other financial assets	Total
	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018					
Financial Assets held at FVTPL	-	-	-	-	**-**
Financial Assets held at Amortised cost	78	120	148	159	**505**
Financial assets held at FVOCI	-	-	-	-	**-**
Total at 31st March 2018	**78**	**120**	**148**	**159**	**505**
Classification under IFRS 9 as at 1st April 2018					
Financial Assts designated to FVTPL	-	-	-	-	**-**
Financial Assets mandated to FVTPL	-	-	-	-	**-**
Financial Assets measured at amortised cost	78	120	148	159	**505**
Financial Assets measured at FVOCI	-	-	-	-	**-**
Total at 1st April 2018	78	120	148	159	**505**
Changes due to change in measurement attribute	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Change in carrying amount	-	-	-	-	**-**

12.3 Movement in loss allowances due to application of IFRS 9

	Cash and cash Equivalents	Trade and other receivables - NHSE bodies	Trade and other receivables - external	Other financial assets	Total
	£000s	£000s	£000s	£000s	£000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (i.e. the 1718 Closing Provision)	-	-	-	-	**-**
Financial assets held at FVOCI	-	-	-	-	**-**
Total at 31st March 2018	**-**	**-**	**-**	**-**	**-**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	-	-	-	-	**-**
Financial Assets measured at FVOCI	-	-	-	-	**-**
Total at 1st April 2018	**-**	**-**	**-**	**-**	**-**
Change in loss allowance arising from application of IFRS 9	**-**	**-**	**-**	**-**	**-**

13 Cash and cash equivalents

	2018-19	2017-18
	£'000	£'000
Balance at 01 April 2018	78	169
Net change in year	(77)	(91)
Balance at 31 March 2019	**1**	**78**
Made up of:		
Cash with the Government Banking Service	1	78
Cash and cash equivalents as in statement of financial position	**1**	**78**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**1**	**78**

14 Trade and other payables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,524	-	1,788	-
NHS payables: Capital	-	-	-	-
NHS accruals[1]	6,022	-	2,741	-
NHS deferred income	5	-	15	-
Non-NHS and Other WGA payables: Revenue[2]	1,920	-	1,418	-
Non-NHS and Other WGA accruals	6,592	-	6,407	-
Non-NHS and Other WGA deferred income	29	-	-	-
Social security costs	62	-	51	-
VAT	-	-	-	-
Tax	59	-	43	-
Payments received on account	-	-	-	-
Other payables and accruals[3]	3,512	-	2,158	-
Total Trade & Other Payables	**20,723**	**-**	**14,622**	**-**
Total current and non-current	**20,723**		**14,622**	

[1] The increase in NHS accruals mainly relates to outstanding payables with our key NHS Foundation Trust provider (RUH) for the year

[2] The increase relates to payables for the year relating to CHC and Mental Health placements

[3] Other payables include £271k outstanding pension contributions at 31 March 2019. There were also increases for prescribing, mental health and primary care including rates.

14.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other borrowings (including finance lease obligations)	Other financial liabilities	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at FVTPL	-	-	-	-	-	**-**
Financial Assets held at Amortised cost	-	4,529	9,983	-	-	**14,512**
Total at 31st March 2018	**-**	**4,529**	**9,983**	**-**	**-**	**14,512**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities designated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities mandated to FVTPL	-	-	-	-	-	**-**
Financial Liabilities measured at amortised cost	-	4,529	9,983	-	-	**14,512**
Financial Assets measured at FVOCI	-	-	-	-	-	**-**
Total at 1st April 2018	-	4,529	9,983	-	-	**14,512**
Changes due to change in measurement attribute	-	-	-	-	-	**-**
Other changes	-	-	-	-	-	**-**
Change in carrying amount	-	-	-	-	-	**-**

15 Other liabilities	**Current 2018-19**	**Non-current 2018-19**	Current 2017-18	Non-current 2017-18
Lease incentives	-	-	-	-
Other	-	-	-	-
Total	**-**	**-**	**-**	**-**
Total current and non-current	**-**		**-**	

16 Provisions

	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Redundancy	41	-	-	-
Continuing care	164	-	-	-
Total	**205**	**-**	**-**	**-**
Total current and non-current	**205**		**-**	

	Redundancy[1] £'000	Continuing Care[2] £'000	Total £'000
Balance at 01 April 2018	**-**	**-**	**-**
Arising during the year	41	164	**205**
Change in discount rate	-	-	**-**
Balance at 31 March 2019	**41**	**164**	**205**
Expected timing of cash flows:			
Within one year	41	164	**205**
Between one and five years	-	-	**-**
After five years	-	-	**-**
Balance at 31 March 2019	**41**	**164**	**205**

[1] This relates to a redundancy provision for one member of staff due to leave the organisation in 2019-20.

[2] This relates to an increased provision for continuing care based on estimated retrospective claims for a preceding period.

17 Commitments

17.1 Other financial commitments

The NHS clinical commissioning group has not entered into any non-cancellable contracts.

18 Financial instruments

18.1 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 Bath and North East Somerset 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.

18.1.1 Currency risk

The Bath and North East Somerset 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 Bath and North East Somerset clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.

18.1.2 Interest rate risk

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

18.1.3 Credit risk

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

18.1.4 Liquidity risk

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

18 Financial instruments cont'd

18.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Trade and other receivables with NHSE bodies	569		569
Trade and other receivables with other DHSC group bodies	44		44
Trade and other receivables with external bodies	133		133
Other financial assets	1		1
Cash and cash equivalents	1		1
Total at 31 March 2019	**747**	**-**	**747**

18.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Trade and other payables with NHSE bodies	687		**687**
Trade and other payables with other DHSC group bodies	12,171		**12,171**
Trade and other payables with external bodies	4,200		**4,200**
Other financial liabilities	3,512		**3,512**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2019	**20,569**	**-**	**20,569**

19 Operating segments

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

20 Pooled budgets

The Clinical Commissioning Group has Pooled Budget arrangements with Bath and North East Somerset Council under section 31 of the Health Act 1999.
The pools are hosted by Bath and North East Somerset Council.
There are five Pooled Budgets being Community Equipment, Better Care Fund, Children & Young People with multiple & complex needs, Mental Health and Adult Learning Difficulties.
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	**59,547**	32,050	21,730	3,078	2,486	203
Bath & North East Somerset Clinical Commissioning Group	**48,480**	37,994	6,638	2,983	392	473
Income from client contributions	**2,858**		2,765			93
Grant Funding	**0**					
Total Funding	**110,885**	70,044	31,133	6,061	2,878	769
Net overspend/(underspend) funded as detailed below						
Bath & North East Somerset Council	(72)	0	(73)	(172)	173	
Bath & North East Somerset Clinical Commissioning Group	342	0	(22)	337	27	
Total Overspend/(Underspend)	**270**	0	(95)	165	200	0

The Memorandum Accounts for Children and Young People with Multiple and Complex Needs was signed on 10th April 2019 and all the other accounts were signed on 23rd April 2019 by the Chief Financial Officer of Bath & North East Somerset Local Authority.
These statements confirm that the Memorandum Accounts accurately disclose the income received and expenditure incurred in accordance with the Partnership Agreement, as amended by subsequent agreed variations, entered into under section 75 of the NHS Act of 2006.
The NHS clinical commissioning group shares of the income and expenditure handled by the pooled budget in the financial year were:

	2018-19	2017-18
	£'000	£'000
Income	0	0
Expenditure	48,822	46,505

21 Related party transactions

Details of related party transactions with individuals are as follows:
Note: These include payments to practices under normal course of business where the GPs are partners of those practices are not exceptional payments in nature.

		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	934	0	46	2
St Chad's Surgery[1]	Dr Elizabeth Hersch	2,081	0	144	1
St James Surgery[1]	Dr Ian Orpen	109	2	0	0
Chew Medical Practice[1]	Dr Timothy Sephton	2,573	0	196	0
Widcombe Surgery[1]	Dr Daisy Curling	763	0	85	0
Swindon CCG	Tracey Cox[2]	168	0	0	22
Wiltshire CCG	Tracey Cox[2]	580	464	4	25

[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. The GPs are recognised as related parties as they are key decision makers for the practices. 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] Tracey Cox is the Chief Executive Officer for BSW covering BaNES, Swindon and Wiltshire CCGs from 1st March 2019.

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.

22 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.

23 Losses and special payments

The Clinical Commissioning Group has no losses and special payment cases to report in 2018-19.