NHS
Bath and North East Somerset
Clinical Commissioning Group

Healthier Stronger Together




Annual Report and Accounts
2013/14

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Contents

Annual Report

Statements by the Accountable Officer

Annual Accounts

Appendix

Annual **Report**

1 Member Practices' Introduction

The Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) came into being on 1 April 2013. From the start we have had a structure designed to involve member practices in the business and governance of the organisation in a variety of ways. This includes a formal Council of Members to approve key items including our strategic plans and Annual Report and Accounts; monthly Forum meetings open to GPs and Practice Managers and providing regular information and discussion on commissioning and provision of services; cluster meetings to focus on services and issues for population groups of around 40,000 people, led by Board level representatives; and direct involvement in individual projects and in the development of the CCG's future plans.

We continue to build on this foundation with a focus on maintaining and increasing member engagement in the context of the challenges faced by primary care and the wider health community, and have recently completed a survey to understand areas for development.

The Council of Members met initially shortly before the CCG came into being, to approve our plans for 2013/14, and achieved excellent attendance and engagement and unanimous approval. We met again in December 2013 for an update on our emerging 5 Year Strategic Plan, and in March 2014 to approve our 2 Year Operational Plan for 2014-16 and our 5 Year Strategic Plan for 2014-19, again with excellent attendance and unanimous approval.

In our first year we have made good progress in developing our understanding of the health priorities for our local community, and of how well we currently perform in meeting health need through high quality services that deliver good value for money. We have used a combination of internal performance and quality information and external benchmarking and review outcomes alongside our own experiences and insights and feedback from our patients. We have enjoyed success in delivering our in-year objectives and in making progress towards our longer term aims, with examples including:

- Commissioning of the new Urgent Care Centre
- Effective application of national winter pressures funding to improve whole system engagement and coordinated action
- Commissioning of new services for talking therapies, alcohol liaison, and dementia support and a new cluster-based service model for community teams
- Innovative pilot projects for patient feedback on heart failure services and for a Wellbeing College
- Enhanced focus on quality initiatives, quality monitoring programmes and the development of quality improvement schemes (CQUINS) with providers
- Improved and streamlined supporting systems including the arrangements for Individual Funding Requests, contracting for healthcare services and performance reporting
- Preparation for the introduction of Personal Health Budgets

Acting through the Governing Body, we have established and strengthened relationships with a wide range of partner organisations and other important stakeholders including Bath and North East Somerset (B&NES) Council, local health and social care providers, neighbouring CCGs, NHS England, our patients, their carers, and the wider public of Bath and North East Somerset.

We have addressed key areas requiring improvement or intervention including the inherited NHS 111 local contract; performance against the national four hour wait target for Accident and Emergency treatment; safeguarding children including enhanced standards in contracts with providers; and engaging with stakeholders to review local rheumatology pathways to inform future options for this service.

We have used a questionnaire based approach to ascertain and evaluate member practices' views on the effectiveness of the CCG and of the Governing Body, with questions exploring understanding of CCG priorities, effectiveness of communications and decision-making. A significant majority of respondents indicated a level between adequate and very good across all these areas. Investigation of a wider range of communication tools was identified as a key area for further work.

The Governing Body is undertaking a further review of its own structure and ways of working to identify opportunities to increase effectiveness, and will collate the results of this with the results of the member practices' feedback to create a combined action plan.

2 Strategic Report

2.1 Legislative Requirements

We are required to explain in our Annual Report what actions we have taken to meet certain key statutory duties. Our Constitution sets out the general arrangements we have put in place to meet our responsibilities, and here we set these out and describe the specific actions we have taken during 2013/14.

2.1.1 Act with a view to securing continuous improvement to the quality of services by:

a) Delegating responsibility for acting with a view to securing continuous improvement to the quality of services to the Governing Body;
b) Delegating operational lead responsibility for continuous improvement to the quality of services to a named nurse lead;
c) Adopting a Quality Strategy that is approved by the Governing Body; and
d) Delegating responsibility for the review of quality of services to the Quality Committee.

The Quality Committee has led the development of monthly Quality and Patient Experience reporting, bringing together information from complaints, patient surveys, incidents and the Friends and Family Test to highlight both good practice and emerging themes requiring action. The Director of Nursing is the Board Member responsible for quality improvement within the CCG. The Board approved the CCG Quality Strategy in September 2013.

2.1.2 Have regard to the need to reduce inequalities by:

e) Adopting an annual commissioning plan that reflects the Group's commitment to reducing inequalities in access to services and outcomes achieved; and
f) Embedding the requirement to consider the reduction of inequalities in individual strategies, policies and decision-making processes.

The CCG Board approved the Annual Operating and Financial Plan for 2013/14 in April. The Operational Leadership Team (OLT) monitors progress on the annual operating plan with review and approval on planned service changes and developments and progress on the CCG's Quality, Innovation, Productivity and Prevention (QIPP) schemes.

The CCG undertakes equality impact analysis as an integral part of reviewing and developing service specifications and all committee papers require consideration of the equality impact of the subject matter. As a result of the work to establish an Urgent Care Centre, it was identified that the needs of gypsies and travellers were not being met and as a result a Gypsy and Traveller Family Outreach service was established.

The Board reviewed progress on the CCG's Equality and Diversity Action Plan and established new Equality objectives at its January 2014 meeting.

2.1.3 Make arrangements to secure public involvement in the planning, development and consideration of proposals for changes and decisions affecting the operation of commissioning arrangements by:

a) Designating the Lay Member (patient and public involvement) and the Chair as lead Governing Body members for public involvement;
b) Establishing a Patient and Public Engagement Forum to harness the contributions of patients, their carers and representatives, and the public;
c) Working closely with Local Healthwatch;
d) Adopting a Communication and Engagement Strategy that is approved and monitored by the Governing Body;
e) Embedding the requirement to secure public involvement in individual strategies, policies and decision-making processes;
f) Delegating responsibility for the management of communications and consultation processes to the OLT, including publishing information about health services on the CCG's website and through other media;
g) Publishing a procurement strategy; and
h) Where it has to consult formally on changes, taking account of the seven criteria laid out in the Cabinet Office's Code of Practice on Consultation.

JP Sanders was the Lay Member for public and patient involvement between April 2013 and December 2013. A new Lay Member, Suzannah Power, took up her role in February 2014 and attended her first Board Meeting in March. The CCG has recently undertaken a series of engagement events to recruit members to the 'Your Health, Your Voice' engagement group, which meets for the first time in June 2014. Healthwatch representatives attend the Quality Committee meetings and have participated in the 'Call to Action' engagement events organised by the CCG in the Autumn of 2013 and recent stakeholder engagement events supporting the development of the CCG's 5 Year Strategy.
The shadow board of the CCG approved a Communication and Engagement Strategy, which was formally adopted by the CCG Board in April 2013.

The CCG undertakes quality impact analysis as an integral part of reviewing and developing service specifications, and all committee papers for strategy and policy development and approval require consideration of engagement and consultation requirements.

The CCG's website is updated regularly to reflect key developments. The CCG regularly publishes information in Council Connect, a quarterly publication that is distributed to all households in BaNES.

Member practices receive regular updates through the monthly GP Forum and bulletins. The CCG attends the BaNES Wellbeing Policy Development and Scrutiny meeting and provides a regular update on key issues.

The CCG adopted a Procurement and Contestability Framework at the point of authorisation and published its procurement intentions for 2013/14 as part of its 2013/14 commissioning intentions.

There have been no formal consultations regarding service change during 2013/14.

2.1.4 Work in partnership with its local authority to develop joint strategic needs assessments and joint health and wellbeing strategies by:

a) Being an active member of the Bath and North East Somerset Health and Wellbeing Board;
b) Participating in locally established arrangements for the development of a joint strategic needs assessment and a joint health and wellbeing strategy, including working groups, engagement events and formal approval processes; and
c) Designating the Chair as lead Governing Body member for this function.

The CCG has three representatives on the Health and Wellbeing Board, the Chair of the CCG, the Clinical Accountable Officer and the Lay Member for Audit. The Board gave support to the Health and Wellbeing Strategy at a board meeting in July 2013. The Chair of the CCG is Vice Chair of the Health and Wellbeing Board. The CCG is in the process of developing a 5 Year Strategy and members of the Health and Wellbeing Board have been engaged in the development to ensure synergy with the priorities of the Joint Health and Wellbeing Strategy.
We certify that the Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

2.2 Nature, Objectives and Strategies of the Clinical Commissioning Group

BaNES CCG was established as a statutory body on 1 April 2013 and was licensed with no conditions.
The CCG's headquarters are based at St. Martin's Hospital in Bath. Office accommodation is shared with local authority commissioning staff and other partner organisations including Central Southern Commissioning Support Unit (CSCSU), and the site is shared with providers including Sirona Care and Health and Avon & Wiltshire Mental Health Partnership NHS Trust (AWP).

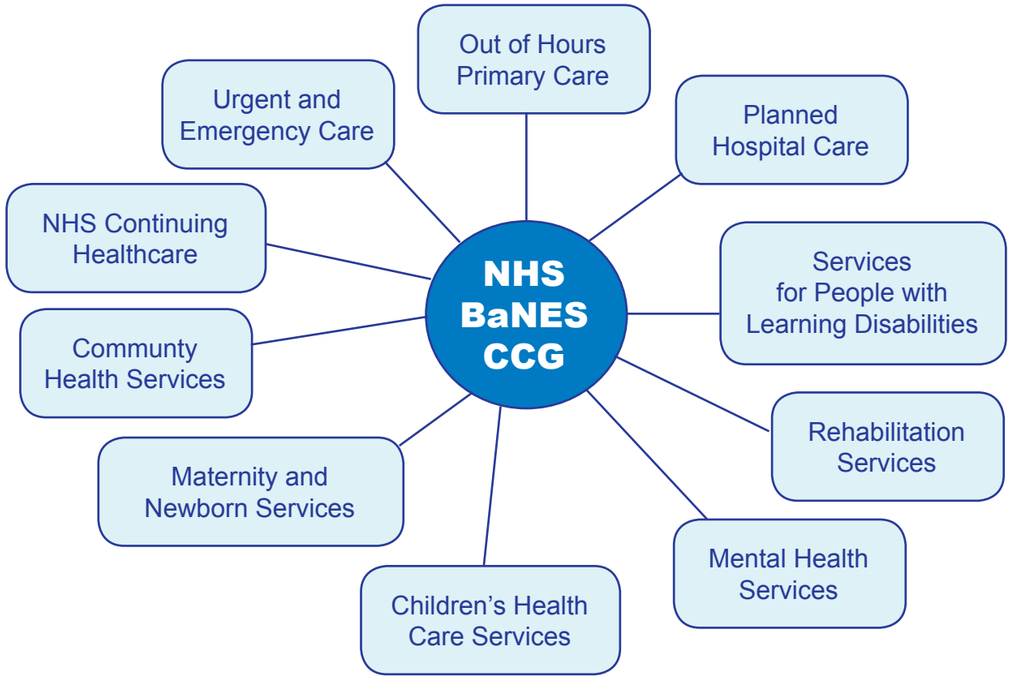
Our mission statement agreed at the point of authorisation and refined recently as part of the CCG's five year strategic planning process is:

To lead our health and care system collaboratively through the commissioning of high quality, affordable, person centred care which harnesses the strength of clinician led commissioning and will empower and encourage individuals to improve their health and wellbeing status.

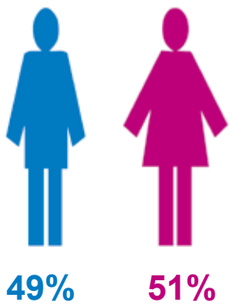
This is encapsulated in our strap line:

"Healthier, Stronger, Together"

The CCG is responsible for commissioning a range of healthcare services as set out below.



The latest (2011) population estimates show there were **177,643** residents in BaNES. The number of patients registered with BaNES General Practices is slightly higher than the resident population, at 199,501 patients (March 2014). The resident population sex profile remains largely consistent compared with previous years, with a 49% / 51% male/female split.



Source: BaNES JSNA http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki and http://www.hscic.gov.uk/catalogue/PUB13365

The age profile is largely consistent with the UK as a whole, except for the 20-24 age bracket, which accounts for 10% of the population as opposed to 7% seen nationally. A larger proportion of people are in this age bracket range as a result of the student population at two universities in BaNES.

The 2011 census showed our population to be **90% White British**, with the next two largest groups being **3.8% (approximately 6,600) Other White**, and **2.6% (approximately 4,500) Asian or Asian British descent**. Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West.

Overall, **BaNES is one of the least deprived authorities** in the country, ranking 247th of 326 English authorities and 49th out of 56 Unitary Authorities. Although the level of deprivation is lower than average, **approximately 3,800 children live in poverty**.

2.2.2 The local external environment within which the CCG operates

The CCG operates within a complex provider landscape in and surrounding BaNES. Several of our local providers are still aspirant NHS Foundations Trusts, including the Royal United Hospital, Bath, North Bristol NHS Trust and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP). We also have a well-developed market for elective care with a high number of independent sector providers including BMI Bath and Circle Bath and Independent Sector Treatment Centres run by Care UK at Emerson's Green and Shepton Mallet.

Community services are provided locally by Sirona Care & Health, an independent community interest company who provide an integrated community health and social care services on behalf of the CCG and local authority. Integrated health and social care services to people with mental health problems are provided by multi-disciplinary teams that are co-located through partnership arrangements between the Council, CCG and with AWP.

The 27 GP practices in BaNES are also a key component of our provider landscape and will continue to play a fundamental role in the delivery of healthcare to our population. Given the proportion of all NHS contacts (between 80-90%) that involve our practices, the strategic importance of practices to continue working effectively with the CCG as a main provider of healthcare is clear.

The role of practices as partners of the CCG is covered in 2.4.

2.2.3 Our Objectives and Strategy in Our First Year

In our first year of operation the CCG developed six strategic objectives:

1. Responding to the challenges of an aging population
2. Improving quality and patient safety
3. Promoting healthy lifestyles and wellbeing
4. Improving the mental health and wellbeing of the population
5. Improving access and consistency of care
6. Reducing inequalities and social exclusion

These translated into a number of core organisational and service priorities for our first year of operation:

Objectives

1	To continue to re-design and re-shape the local urgent care system to respond to local system challenges and reduce escalation requirements.
2	To enhance long term conditions management through targeted work in dementia, diabetes and heart failure.
3	To complete best value reviews across a range of areas including ISTC activity, CHC, free nursing care and prescribing.
4	To improve End of Life Care Management across all care sectors.
5	To engage and direct primary care and community resources to support the CCG's core strategic aims.
6	To develop quality initiatives including CQUINs to secure improvements and better outcomes for our patients.
7	To develop the CCG's capacity and capability to deliver our over-arching strategy.
8	To continue to develop relationships with our key partners to ensure alignment of strategy and service objectives.

These organisational priorities formed the basis of personal objective setting for all CCG staff.

2.3 Development and Performance of the Clinical Commissioning Group for the Period under Review and in the Future

2.3.1 Environmental, Social and Community Issues

Working with local stakeholders

The CCG is an active member of both of the Health and Wellbeing Board and Public Services Board in BaNES. Membership of these groups enables the CCG to gain a wider perspective and understanding of not just the health issues that impact on our local population but the wider issues affecting people in BaNES, and other determinants and influences on health such as housing, social exclusion and loneliness, transport and education. During 2013/14 the CCG has regularly attended the Wellbeing Policy Development and Scrutiny Panel meeting (also known as Overview and Scrutiny). This panel reviews and scrutinises both the Council and other organisations' work and service delivery and examines issues that impact on the local community with specific duties for health and community safety.

Procurement of new services

Under Social Value legislation, public sector organisations are required to consider how the service they commission and procure might improve the economic, social and environmental wellbeing of the area that they serve. Social Value is a broad term and can be interpreted in a number of ways but could mean a local person for a local job or a public body contracting with a private firm who uses local resources to service its contract requirements. The Social Value Act came into effect on 31 March 2013. The CCG considers the Social Value implications of all prospective procurement processes and where appropriate incorporates its responsibilities under the Act in key procurement documentation. The CCG will take into account economic, social and environmental value, not just price, when commissioning healthcare services. This will involve requesting relevant policies or statement at the pre-qualification stage of the procurement process and seeking more specific information at the Invitation to Tender (ITT) stage where it can be measured and linked to the performance of the contract.

2.3.2 Progress against agreed targets

In 2013/14 the CCG has focused on national performance targets and primarily the principles and rights in the NHS Constitution. Many of the indicators are reported and reviewed monthly as part of our performance framework. Delivery of key national targets has required working in partnership with local providers.

2.3.2.1 Urgent Care Targets

Based on historical performance the most challenging performance targets for the CCG would be the NHS Constitution targets for Urgent and Emergency Care. Below is a table summarising the CCG's urgent care performance. More detail in terms of our approach to improve poor performance over the winter of 2012/13 is covered in 2.4.6

Performance in Urgent and Emergency Care against NHS Constitution Standards

NHS Constitution Standard	Target	2013/14 Results	Commentary	
% of A&E attendances taking under 4 hours	95%	94%	A	This is the RUH results as CCG level (combined provider scores) are not available for A&E attendances. For the RUH the full year amber performance is due to poor performance at the beginning of the year and then since January. Performance was significantly better than 2012/13 particularly for the Winter period. The RUH had the third most improved results in the South of England in 2013/14.
Ambulance - category A (red 1) ¬- % attendances within 8 minute response time	75%	70%	A	This is total South West Ambulance Service FT (SWAST) North Division results. The Ambulance Indicators dipped significantly during 2013/14 and started to show signs of recovery at the end of the year. SWAST are working with commissioners on a red recovery plan for their North Area. The CCG are working to improve the results for the BaNES area.
Ambulance - category A (red 2) - % attendances within 8 minute response time	75%	72%	A	
Ambulance - category A - % attendances within 19 minute response time	95%	94.9%	A	
Mixed Sex Accommodation breaches	none	24	R	This shows the RUH results only. The RUH have had six incidents, all in the Medical Assessment Unit (MAU) when the Emergency Department was very busy. Actions have been put in place to improve the patient management in MAU but occasionally patient safety has been put first.

The information in these performance tables relate to all BaNES patients unless otherwise stated.

2.3.2.2 NHS Constitution - Access to Treatment - Planned Care

The Royal United Hospital Bath (RUH) is our key provider of acute services though some specialist services are contracted with North Bristol Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHB). Overall, the Trust has performed well.

Performance in Access to Treatment for Planned Care against NHS Constitution Standards

NHS Constitution Standard	Target	2013/14 Results	Commentary	
Diagnostic test waiting times - under six week waits	99%	99%	G	Diagnostic performance was very good, meeting the target 11 out of 12 months. This indicator was Amber in June 2013 due to a scanning machine fault. Waiting lists were on a downwards trend in the second half of the year. The number of people waiting for more than six weeks was also below 12 for the last six months, better than the earlier months this year and all of 2012/13.
Referral to Treatment Times				
i. The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	90%	93%	A	This indicator has performed above target in all months except July 2013. In July 2013 the RUH undertook an exercise to clear their backlog and dropped to 78% bringing the BaNES figure down to 89.7% in July, just below target.
ii. The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	95%	96%	A	This indicator has been above target for BaNES every month in 2013/14. UHB have struggled to meet the target and have been Amber or Red in all but one month. NBT were amber in six months of the year. At the beginning of the year, UHB took over services including the Head and Neck waiting lists from NBT. NBT took over services including urology from UHB. Both UHB and NBT have recovery plans in place that are being reviewed for 2014/15.
iii. The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	92%	94%	A	This indicator has been above target for BaNES every month in 2013/14. UHB has been Amber eight months of the year. NBT have been Amber or Red six months of the year (see comments above).
Cancelled Operations - not rebooked within 28 days (RUH)	1%	16.3%	R	This indicator is shown for the RUH only. Quarter one results were poor due to cancellations during escalation for urgent care but all other quarters were below the 1% threshold. The 1% threshold is locally set, the national target is 0% but most providers set a threshold around this level.

There is a key access standard that all patients are treated within 52 weeks of referral, there have been 2 breaches of this standard for patients from BaNES in 2013/14, both breaches have been explained and action is being taken to prevent future breaches.

2.3.2.3 NHS Constitution - Access to Treatment - Cancer Waiting Times

Cancer diagnostics and treatment is provided by all three local providers, the Royal United Hospital (RUH), North Bristol Trust (NBT) and University Hospitals Bristol NHS Foundation Trust (UHB). There are nine indicators to meet for access to cancer treatment, depending on the access route, stage of illness and the treatment needed. Sometimes very small numbers of patients go through these pathways and not every target will be met every month. All of the targets have been met for BaNES patients.

Performance in Access to Treatment for Planned Care against NHS Constitution Standards

NHS Constitution Standard	Target	2013/14 Results	Commentary	
All Cancer two week waits	93%	95.7%	G	This indicator has performed above target in all months of 2013/14.
Two week wait for breasts symptoms (where cancer was not initially suspected)	93%	97.0%	G	This indicator has performed above target in all months of 2013/14 except January 2014 (92%).
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	98.5%	G	This indicator has performed below target in December 2013 only when there were three breaches out of 56 patients.
31-day standard for subsequent cancer treatments/ surgery	94%	98.8%	G	This indicator has performed below target in December 2013 only. In December there was one breach out of 15 patients.
31-day standard for subsequent cancer treatments/ anti cancer drug regimens	98%	99.2%	G	This indicator has performed above target in all months except June (95%, one breach out of 20) and December 2013 (95.2%, 1 breach out of 21).
31-day standard for subsequent cancer treatments/ radiotherapy	94%	98.8%	G	This indicator has performed above target in all but one month (Jan 2014 - 93.8%) of 2013/14.
All cancer two month urgent referral to first treatment wait	85%	90.7%	G	This indicator performed below target in May (81%) and November (84.8%) 2013 and March 2014 (82.1%).
62-day wait for first treatment following referral from an NHS cancer screening service	90%	93.7%	G	This is the worst performing indicator with two Amber months (June and Sept) and two Red months (Oct and Nov). The numbers of patients on this pathway is usually small. For example In November three patients out of 10 breached - 70%.
62-Day wait for first treatment for cancer following a consultant's decision to upgrade the patient's priority	90%	98.3%	G	This indicator has performed above target in all months of 2013/14.

2.3.2.4 Quality and Safety

We work with local CCGs and each of our providers to improve the quality and safety of patient care. The quality and safety of provided services is assured through quality schedules, commissioning for quality and innovation indicators (CQUIN), monitoring of the quality impact of cost improvement schemes and site visits at major providers.

We review performance against quality schedules which comprise a range of indicators including safeguarding, healthcare associated infections and patient and staff satisfaction outcomes. Performance in 2013/14 against key quality indicators is shown in the table below.

We have developed our approach to CQUINs during the year and held a well-attended and productive engagement event for provider and commissioner colleagues as part of our preparation for our 2014/15 plan.

Formal quality review groups are in place with our main providers, working collaboratively with our colleague commissioners where appropriate. We also run a series of formal and informal site visits that have been well-received. The visiting teams include lay members from our Board and neighbouring CCG Board where appropriate, as well as key clinical leads. During visits, we focus on areas of good practice as well as areas where performance data indicates potential cause for concern.

We have arrangements in place to ensure that the Quality Committee has oversight of areas of patient safety, patient experience and clinical effectiveness on behalf of the CCG Board. Information, both qualitative and quantitative, is triangulated to achieve a more rounded picture of the services we commission. Benchmarking data is also considered where available.

Quality or Safety Indicator	Target	Year to date (Feb 2014 = 11 mths)		Commentary
Incidence of newly acquired category 2, 3 and 4 pressure ulcers (RUH)	n/a	41		Incidence of newly acquired category 2, 3 and 4 pressure ulcers (RUH)
Number of Never Events	0%	0	G	Number of Never Events
Friends and Family Test response rate (RUH)	15%	23.8%	G	Friends and Family Test response rate (RUH)
Percentage of all adult inpatients who have had a Venous Thrombolytic Embolism (VTE) risk assessment (RUH)	95%	95.4%	G	Percentage of all adult inpatients who have had a VTE risk assessment (RUH)
World Health Organisation (WHO) Surgical Safety Checklist completed for 100% of procedures (RUH)	100%	99.9%	G	WHO Surgical Safety Checklist completed for 100% of procedures (RUH)
Fracture Neck of Femur - % in theatre within 36 hours (RUH)	80%	80.0%	G	Fracture Neck of Femur - % in theatre within 36 hours (RUH)
Healthcare associated infection (HCAI) measure (MRSA) (All CCG patients)	0	4	R	Healthcare associated infection (HCAI) measure (MRSA) (All CCG patients)
Healthcare associated in-fection (HCAI) measure (c. difficile) (All CCG patients)	46	56	R	Healthcare associated infection (HCAI) measure (c. difficile) (All CCG patients)
Healthcare acquired infection (HCAI) measure (c. diff) Adjusted after consultation with CCG (RUH) (Post 72 hour)	29	28	G	Healthcare acquired infection (HCAI) measure (c. diff) Adjusted after consultation with CCG (RUH) (Post 72 hour)

2.3.3 Performance Management Framework

In its first year the CCG has implemented a performance management framework to sit alongside the contract management process and make performance and quality visible and focused to the CCG. Key areas of performance, and particularly those subject to rapid or significant seasonal change, are monitored and reported weekly or monthly as appropriate.

A monthly Integrated Quality and Performance Report (IQPR) comprising key indicators in quality and performance and updates on the commissioned services is produced. Performance is reviewed using this report at all of the OLT and CCG Board meetings.

The first year of the CCG has seen some very positive results of partnership working and improved outcomes for the population we serve.

The CCG in its shadow year undertook a very proactive approach in fostering good relationships with providers and setting out its principles of how it intended to do business. This has enabled us to meet the challenges of our first year of operation robustly and effectively.

2.4 Partnership Working

Below is a commentary on how we have worked with our key partners with a number of successes that have resulted from our work with them: the list is by no means exhaustive, both in terms of our stakeholders and our achievements, but highlights some of our major achievements.

2.4.1 Local Authority

There is a long-standing history of collaboration and joint commissioning between health and social care commissioners in BaNES. Commissioning of adult and children's health and social care has been integrated since 2009 with aligned budgets and common commissioning goals. Our commitment to this model covers the whole of our shared agenda but is most fully realised around adult services, including mental health, learning disabilities, physical and sensory disability, carers and our elderly frail population.

These arrangements are supported by pooled budgets for Learning Disabilities and Children's Services and a series of 256 arrangements. This joint working has been mirrored since 2009 by the provision of community health and social care services for adults through a single management structure.

2.4.2 Health and Wellbeing Board

The CCG continues to play a key role in the Health and Wellbeing Board, with formal representation provided by the CCG's Clinical Chair, Clinical Accountable Officer and our lay member who leads on audit and assurance. One of the successes of last year was the Health and Wellbeing Board peer-to-peer challenge. This recognised the very positive relationships in the Health and Wellbeing Board with a strong emphasis on joint working. However, through the peer-to-peer review, we have been encouraged to be more ambitious.

2.4.3 Public Health

We continue to work closely with Public Health colleagues who support the CCG's work programme especially on helping to reduce inequalities and improving prevention of disease and improved self-care, which will be a significant focus of our 5 Year Plan.

2.4.4 Practices

As well as playing an important role as a provider of healthcare, our practices as members of the CCG play a significant role as partners in helping to deliver the CCG's strategic objectives. To this end, practices are continually involved in the business of the CCG as a commissioner of local health services, and we have used our very successful monthly GP forums to share with practices our thoughts on our 5 Year Plan and they have helped to shape this. We also meet with our practices in the five localities, or cluster groups. These provide a practical way of maintaining the two-way communications between the CCG and the practices: feedback from these meetings helps us to understand the impact of new services at a grass-roots level.

2.4.5 NHS Wiltshire Clinical Commissioning Group

We have worked very closely with Wiltshire CCG around our main provider, the RUH. Joint working on the quality review of services provided by the RUH has been a real success story particularly in improving outcomes of clinical care and developing good working relationships with senior clinical colleagues in all three organisations. Another example of our good working relationship with Wiltshire CCG was in our joint approach in improving the quality of the local 111 service, following a difficult launch of the service in February 2012. Our approach showed that from Board level down through both organisations, we could work very effectively together.

2.4.6 Urgent Care Working Group

The Urgent Care System (UCS) centred on the RUH (which involves BaNES, Wiltshire and Somerset CCG's patients and to a small degree, South Gloucestershire CCG patients) had an extremely challenging winter in 2012/13. Four hour performance was very poor, and the RUH's Emergency Department was frequently under such pressure that there were concerns around clinical safety.

The CCG established an Urgent Care Working Group (UCWG) to oversee implementation of an agreed joint approach to managing the system, designed to deliver significant improvement. The UCWG has had senior level membership from both commissioners and providers in order to improve our decision-making and speed of implementation. One of the successes last summer was a very well-attended simulation event, which helped all the providers involved in urgent care to understand each other's perspectives.

Whilst we have not delivered a consistent four hour performance over the winter 2012/13 period, rapid system recovery at times of high pressure and maintaining a safe clinical service in the RUH emergency department has been achieved.

2.4.7 NHS England

The CCG recognises both the assurance role of NHS England in the latter's relationship to the CCG and its developmental role. We have achieved a productive relationship with NHS England South over the past year: review meetings have been conducted in a positive and collaborative environment. NHS England has encouraged the CCG and given it the space to step up as a local leader and to be more ambitious in its 5 Year Plan and to this end NHS England has played a helpful role of critical friend.

2.4.8 Providers

Whilst we have an extensive number of providers that we conduct business with, our three most significant providers are our local acute trust, our mental health provider and our community health, and social care provider.

2.4.9 Royal United Hospital Bath NHS Trust

The relationship between the CCG and the RUH has been developed at many different levels: a successful, facilitated three-way board meeting last summer between the RUH, Wiltshire CCG and BaNES CCG helped establish the principles with which we aimed to conduct our business with each other. Much work has gone on behind the scenes to develop new pathways of care, particularly heart failure services, hip and knee pathway and dementia care.

Senior leaders from both organisations hold regular meetings and one to ones to ensure we maintain our effective working relationship: success of our approach has been demonstrated by the frequent positive feedback we have had from senior members of the RUH on improved relationships and more effective joint working when compared to the past.

2.4.10 Sirona Care and Health CIC

Sirona is our local community health and social care provider. As mentioned elsewhere in this report, it is one of the few community interest companies that provide both health and social care.Sirona plays a very effective role in our Urgent Care System and good relationships have underpinned this.Regular meetings and one to ones between senior members of both organisations have been established, to ensure we maintain good working relationships. An example of successful working has been the setting up of cluster community teams working with groups of practices to help identify our patients who have the greatest need and support in the community to ensure continued independence and reduce the risk of avoidable hospital admissions. This scheme is in its early stages, but initial reports have been very positive and we fully intend to build on this early success.

2.4.11 Avon and Wiltshire Mental Health Partnership NHS Trust

AWP is our main provider of acute and community mental health services. Relationships between the CCG and AWP have been very positive for some time now and the mental health project board provides a very effective interface between the local authority and the CCG with AWP.

Key successes in the last year have been:

- The launch of the talking therapies service (LIFT) run by AWP
- The bedding in of the primary care liaison service (PCLS)
- The focus of AWP into more effective locality working and the joint working between LIFT and PCLS

The success of this renewed focus on community mental health services would not have happened without an effective relationship between AWP and the CCG. This approach has enabled better integration of community services and more effective support of front-line staff, which has improved better working with our practices and a community mental health service that is more willing to say yes.

2.4.12 Investments

We plan to use both recurrent and non-recurrent investment each year to further the delivery of our operational and strategic plans. To support this we test investment requests and proposals against a range of prioritisation criteria including alignment with national and local objectives, delivery of qualitative and quantitative benefits, wider health and social care system impact, and ability to deliver innovative and transformational change. During 2013/14 we made non-recurrent investments to the value of £4.13m and recurrent investments to the value of £2.12m.

Non-recurrent investment funded risk pooling; transitional support for service changes such as psychological therapies and NHS111; and investing to improve patient experience and outcomes through quality and access improvement initiatives and primary care enhanced service pilots. We also received £4.43m of national funding to support pressures in the urgent care system around the RUH, particularly during the challenging winter period. This funded projects including an increase in Emergency Department staffing at the RUH; expansion of seven day working within the hospital and supporting services; increased placement capacity in social care; and additional capacity in primary care.

We used recurrent investment to increase our contributions to pooled budgets to reflect growth and sustain the benefits of working in partnership with B&NES Council; re-provide a range of services including psychological therapies and non-urgent patient transport; and introduce a virtual ward model within community and primary care.We plan to commit similar amounts of recurrent investment over the next five years in support of our long-term strategy, with additional investment in 2015/16 to support the creation of the Better Care Fund. Priorities will include continuation of successful pilot schemes including those originally funded through national Winter-related funding; investment to release resources, deliver efficiency gains or improve quality in existing services; and investment to deliver our local strategic priorities.

2.5 The Resources, Principal Risks and Uncertainties and Relationships that may affect the CCG's long-term Performance

2.5.1 Resources

The financial resources available to us to support the delivery of our objectives are described in detail in the financial review of our Annual Accounts (section 2.9), supported by the analysis provided by the accounts themselves. To ensure we make best use of our resources we produce operational and strategic plans covering the next five years which ensure our financial and activity plans are strongly aligned with, and support delivery of, our commissioning plans. These plans also consider how we can best use our workforce, local health estate, information technology assets, and organisational and governance structures to deliver our objectives.
To ensure our resources are managed effectively we monitor progress against our plans and check that the services we commission are delivering the expected activity and outcomes for the expected cost, and continue to offer good value for money.

2.5.2 Risks

We detail significant risks identified during 2013/14 in section 6.7 and describe the arrangements for managing risk within the CCG.

2.5.3 Stakeholders

To further the delivery of our objectives and ensure they are aligned with those of the wider health and social care community, we have developed a number of key relationships with partners and stakeholders. These are described in detail in section 2.3.

2.6 Sustainability Report

We recognise the importance of sustainable development and our response to issues such as carbon reduction and climate change, both in terms of our legal and corporate social responsibilities and of the qualitative and financial benefits that can be achieved.

We intend to develop our response in the context of the Public Health England document Sustainable, Resilient, Healthy People and Places: A Sustainable Development Strategy for the NHS, Public Health and Social Care System (January 2014). We will develop a Sustainable Development Management Plan proportionate to our organisational size, including appropriate mechanisms for monitoring, reporting on and evaluating our progress. We will take action to embed sustainability considerations in our business operations and our engagement with the public, patients and their carers, staff and other stakeholders.

We will work with B&NES Council and wider Health and Wellbeing Board partners to ensure our plans are aligned with sustainability considerations as included in the Health and Wellbeing Strategy and Joint Strategic Needs Assessment.

It would be usual to include information on carbon emissions relating to property occupancy in a Sustainability Report. We occupy a building on the St Martin's Hospital site, which from 1 April 2013 was owned by NHS Property Services, who are thus responsible for providing the data to support this aspect of the report. It has not been possible for NHS Property Services to provide this data in respect of 2013/14, but we anticipate that data will be available from 2014/15 onwards.

2.7 Equality Report

In line with the requirements of the Equality Act 2010 and associated public sector equality duty we have published our equality objectives and annual equality report on our website, for more details please visit: www.banesccg.nhs.uk/ccg/equality-diversity.

Since the publication of the equality report we have further reviewed our performance against the equality action plan. As a result we plan to revise our equality and diversity strategy so that action to promote equality is strongly linked to reduction of health inequalities and tangible improvements in patient experiences and outcomes. We are now in the process of setting up an Equality/Health Inequality Task Force to take this work forward and facilitate the implementation of the Equality Delivery System Framework. Our eventual aim is to integrate equalities (including health inequalities, inclusion and Human Rights) issues in every stage of the commissioning cycle.

We are always keen to hear from our service users and employees across the nine protected characteristics on how we can improve patient outcomes and experiences of our services and how we can improve the skills and working conditions for our workforce.

The CCG's Public Sector Equality Duty Report is attached in full in the Appendix.

2.8 CCG Diversity Breakdown

	Male Headcount	Female Headcount
Governing Body Members	6	7
All CCG employees	11	33

There are no employees other than Governing Body members who are on Very Senior Manager pay bands.

2.9 Financial Review

In its first year, the CCG has achieved its statutory financial duties reflecting the strong financial management within the organisation. We closed the year with a total budget of £217.244m and operated within our revenue resources for 2013/14 achieving a total surplus of £3.065m. This is £1.000m in addition to the planned surplus of £2.065m due to the non-materialisation of non-recurrent financial risks in 2013/14.

Planned resource releasing savings of £3.525m were delivered in full due to the successful delivery of many of the original planned schemes, as well as additional schemes captured in the year. The resources released were used to fund the investments described in section 2.3.The administration resource (also referred to as running costs) of £4.660m underspent by £0.261m in 2013/14 although vacancies contributed to this and this underspend does not reflect the underlying position, with the full £4.655m allocation assumed as committed in 2014/15.

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 £3.065m.

	2013/14 £000
Performance for the year ended 31 March 2014:	
Total Net Operating Cost for the Financial Year	214,179
Revenue Resource Limit	217,244
Under/(Over) spend against Revenue Resource Limit	**3,065**

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, CSU recharge, NHS Property Services recharge 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.

	2013/14 £000
Performance for the year ended 31 March 2014:	
Total Administration Cost for the Financial Year	4,399
Administration	4,660
Under/(Over) spend against Allocation	**261**

Better Payment Practice Code – Measure of Compliance

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Compliance is measured as at least 95% of invoices paid within 30 days or within agreed contract terms.

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

	2013/14 Number	2013/14 £000
Non NHS Creditors		
Total bills paid in the year	2,107	37,904
Total bills paid within target	2,025	37,624
Percentage of bill paid within target	96.11%	99.26%

	2013/14 Number	2013/14 £000
NHS Creditors		
Total bills paid in the year	1,698	118,177
Total bills paid within target	1,648	117,734
Percentage of bill paid within target	97.06%	99.63%

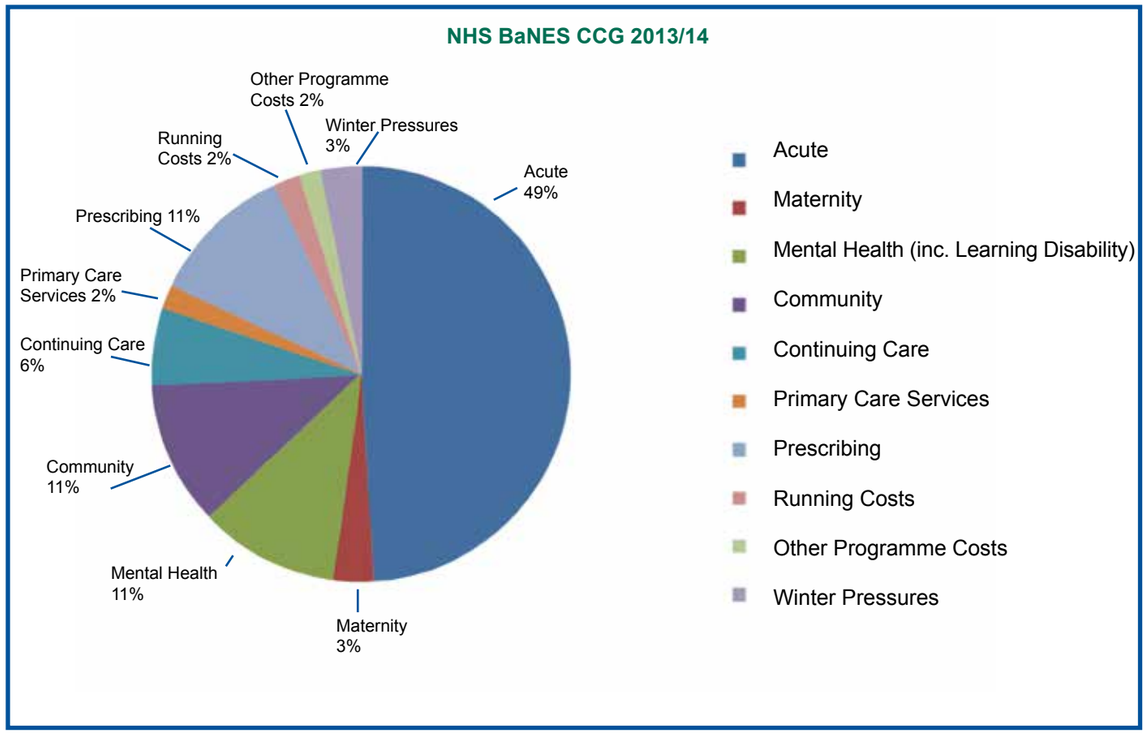
Cash position

Our financial statements show a small cash overdraft (negative balance) of £0.088m as at 31st March 2014. This is due to an administration error by a third party which led to a cash transaction being recorded in 2013/14 instead of 2014/15. The correct cash position as at 31st March 2014 was a £0.003m positive balance.

CCG expenditure by areas of care

We spend money on a range of healthcare services commissioned for the people of BaNES. The chart below shows the types of services provided and illustrates how much we spent on each during 2013/14. Acute healthcare makes up the highest percentage of expenditure (49%) by a considerable margin, with the next largest areas of expenditure being Prescribing, Community Services and Mental Health and Learning Disability which are all similar in value.

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



Future financial position

The Board has approved a budget for 2014/15 which again plans to deliver a surplus of £3.167m. Planned net savings of £3.967m are required to offset increasing costs and activity pressures and to support priority investments. Our 5 Year Strategic Plan indicates resource releasing targets between £3.500m and £4.300m for the years to 2018/19.

Financial statements

The CCG's main financial statements for 2013/14 are summarised below. 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.

Statement of comprehensive net expenditure for year ended 31st March 2014

	2013/14 £000
Administration costs and programme expenditure	
Gross employee benefits	2,421
Other costs	215,730
Other operating revenue	(3,972)
Net operating costs for the financial year	**214,179**
Of which:	
Administration costs	
Gross employee benefits	2,079
Other costs	2,768
Income	(448)
Net administration costs for the financial year	**4,399**
Programme expenditure	
Gross employee benefits	342
Other costs	212,962
Income	(3,524)
Net programme expenditure for the financial year	**209,780**

Statement of financial position as at 31st March 2014

	2013/14 £000
Non-current assets	
Property, plant and equipment	0
Trade and other receivables	0
Total non-current assets	**0**
Current assets	
Inventories	0
Trade and other receivables	2,161
Cash and cash equivalents	(88)
Total current assets	**2,073**
Total assets	**2,073**
Current liabilities	
Trade and other payables	(10,338)
Provisions	(343)
Total current lisbilities	**(10,681)**
Total assets less current liabilities	**(8,608)**
Total assets employed	**(8,608)**
Financed by:	
Taxpayers' equity	
General fund	(8,608)
Revaluation reserve	0
Total taxpayers' equity	**(8,608)**

Statement of cash flows for the year ended 31st March 2014

	2013/14 £000
Cashflow from operating activities	
Net operating cost for the financial year	(214,179)
Increase in trade and other receivables	(2,161)
Increase in trade and other payables	10,338
Increase in provisions	343
Net cash outflow from operating activities	**(205,659)**
Cash flows from financing activities	
Net funding received	205,571
Net cash inflow from financing	**205,571**
Net increase/(decrease) in cash and cash equivalents	**(88)**
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year	**0**
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	**(88)**

Simon Douglass
Clinical Accountable Officer
5 June 2014

3 Members' Report

3.1 Detail of the members of the Membership Body and Governing Body

The following practices comprise the Members of NHS BaNES CCG:

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

The Chair of the CCG from 1st April 2013, throughout the year and up to the signing of the Annual Report and Accounts was Dr Ian Orpen.

The Clinical Accountable Officer of the CCG from 1st April 2013, throughout the year and up to the signing of the Annual Report and Accounts was Dr Simon Douglass.

The membership of the Governing Body, known locally as the Board, was as follows during 2013/14:

Dr Ian Orpen
Chair of the CCG

Dr Simon Douglass
Clinical Accountable Officer

Dr Ruth Grabham
Clinical Director

Tracey Cox
Chief Operating Officer

Sarah James
Chief Financial Officer

Dawn Clarke
Director of Nursing and Quality and Registered Nurse

Dr Jim Hampton
GP Cluster Commissioning Lead

Dr Elizabeth Hersch
GP Cluster Commissioning Lead

Dr Shan Mantri
GP Cluster Commissioning Lead

Helen Harris
Practice Manager Cluster Commissioning Lead from June 2013

Roger Stead
Practice Manager Cluster Commissioning Lead until April 2013

Dr Mark Daly
Secondary Care Consultant

John Holden
Lay Member (Audit and Governance) and Vice Chair of the CCG

JP Sanders
Lay Member (Patient and Public Involvement) until December 2013

Suzannah Power
Lay Member (Patient and Public Involvement) from February 2014

3.2 Audit Committee

The membership of the Audit Committee during 2013/14 has been as follows:

- **John Holden** – Committee Chair and Lay Member (Audit and Governance)
- **JP Sanders** – Lay Member (Patient and Public Involvement) until December 2013
- **Suzannah Power** – Lay Member (Patient and Public Involvement) from February 2014
- **Dr Mark Daly** – Secondary Care Consultant

The Chief Financial Officer and the Clinical Accountable Officer generally attend meetings of the Audit Committee, together with representatives from internal and external audit.

Please refer to the Governance Statement for details of the other committees of the Board and to section 4.14 for the Membership Body and Governing Body Profiles and to section 4.14 for details of conflicts of interest.

3.3 Relevant Disclosures

The CCG has not been the recipient of any political or charitable donations during 2013/14.

There have been no important events since the end of the financial year affecting the CCG.

There are no significant likely future developments at the CCG.

There are no significant activities in the field of research and development forecast.

There are no branches of the CCG outside the UK.

3.4 Pension Liabilities

The Annual Accounts detail the treatment of pension liabilities; see Note 4.5.

3.5 Sickness Absence Data

Sickness absence data is provided in note 4.3 in the Annual Accounts.

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

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

3.6 External Audit

The CCG's external auditor, Grant Thornton, was paid £73,200 for Audit Services for the reporting year 2013/14 relating to statutory audit work carried out. These statutory audit services include both the audit of the CCG's financial statements and related reporting, and other statutory activities such as value for money work. The basis for value for money work in 2013/14 is a tailored approach, with a focus on the risks relating to CCG establishment as new bodies.

3.7 Disclosure of Serious Incidents

The CCG had one breach of data security during 2013/14. This lapse of data security was reported immediately to the Information Commissioner and has been confirmed by recent guidance as being at severity 0 (minor breach). The Information Commissioner was satisfied with actions taken by the CCG.

3.8 Cost Allocation and Setting of Charges for Information

We certify that the CCG has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

3.9 Principles for Remedy

The CCG follows the principles of good administration outlined by the Parliamentary and Health Service Ombudsman in the Principles for Remedy guidance published in 2007 and considers the impact of the organisation's actions on the individual concerned. The CCG is committed to ensuring that challenges facing patients raised as concerns or complaints are captured and that, where appropriate, changes in commissioning strategies are recommended to improve patient experience. The key principles for remedy the CCG follows which form part of its complaints handling procedure are:

1. Getting it Right
2. Being Customer Focused
3. Being Open and Accountable
4. Acting Fairly and Proportionately
5. Putting things Right
6. Seeking Continuous Improvement

3.10 Employee Consultation

We are a small employer of some 44 staff. The workforce is made up of employees from a wide variety of professional groups, in many cases in small numbers and a large proportion of employees sit within the management delivery team.

In building effective and meaningful partnership working with staff and staff side representatives, the CCG has developed partnership arrangements that are sufficiently flexible to accommodate and reflect the workforce in terms of professional group and size.We recognise all of the trade unions outlined in the national Agenda for Change terms and conditions handbook who have members employed within the organisation.

Local arrangements are determined on an ad hoc basis where formal staff consultation is required, to ensure appropriate and effective consultation arrangements are in place. This approach has worked well in the first year as a CCG although arrangements may be reviewed in light of our 5 Year Strategy to consider where arrangements may be strengthened going forward.

We have has delegated negotiations over HR policy development to the CSCSU Staff Partnership Forum (SPF). The CSCSU SPF considers collated feedback from the CCG as part of this process and ensures staff and trade unions are equally engaged in the development process. Policies are formally ratified and adopted by the CCG's Operational Leadership Team (OLT) prior to publication.

Communication within the CCG is carefully managed and staff are encouraged to engage with the various methods of communications covering a wide range of issues and activities. The CCG holds regular staff briefings directly led by the Clinical Accountable Officer and Chief Operating Officer where staff are invited to share their views and ask questions. This is complemented by an electronic version of the document which is cascaded for those who are unable to attend the briefings in person. A regularly updated intranet provides key information for staff and annual staff engagement survey results will be reported to the CCG Governing Body and used to involve staff in creating key objectives and actions to drive improvement in staff experience.

Managers hold regular one-to-one meetings with staff and a robust appraisal system ensures all staff work towards clearly defined personal objectives which are supported with learning, training and development opportunities

3.11 Disabled Employees

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 our 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 publish 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.

3.12 Emergency Preparedness, Resilience and Response

We certify that the CCG has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The CCG regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Board (Governing Body).

3.13 Statement as to Disclosure to Auditors

Each Individual who is a member of the BaNES Board at the time the Members' Report is approved confirms:

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

Simon Douglass
Clinical Accountable Officer
5 June 2014

4 Remuneration Report

4.1 Remuneration Committee Report

The CCG has a Remuneration Committee, the role of which is to determine and approve the remuneration package for senior managers and CCG employees. Membership of the Remuneration Committee is made up of the following members:

- **John Holden** – Chair and Lay Member (Audit & Governance)
- **JP Sanders** - Lay Member (Patient and Public Involvement) until December 2013
- **Suzannah Power** – Lay Member (Patient and Public Involvement) from February 2014
- **Dr Ian Orpen** – Chair of the CCG
- **HR Specialist** from NHS CSCSU (in attendance only, no voting rights)

During 2013/14 two formal meetings of the CCG Remuneration Committee were held. Details of attendance are shown below:

Remuneration Committee Member:	23rd May 2013	20th June 2013
John Holden	Attended	Attended
JP Sanders	Attended	Attended
Suzannah Power	Not in post at date of meeting	
Dr Ian Orpen	Attended	Attended

In addition, the Chair of the Remuneration Committee consulted with Dr Andrew Havers and Dr Kate Jenkins as delegated representatives of the Membership to seek advice on the appropriate level of remuneration for the Clinical Chair and Clinical Accountable Officer.

4.2 Policy on Remuneration of Senior Managers

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

Executive Directors pay is set in accordance with the guidance *Clinical Commissioning Groups: Remuneration Guidance for Chief Officers and Chief Finance Officers.* Existing Very Senior Manager and higher banded Agenda for Change payscales, terms and conditions apply. For other Board members the CCG relied on available guidance and comparative data from Primary Care Trusts (PCTs) and other 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.

4.3 Senior Managers Performance Related Pay

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

4.4 Policy on Senior Managers Contracts

Executive senior managers excluding the Clinical Accountable Officer are on permanent NHS contracts, with terms and conditions including duration, notice periods and termination payments in accordance with existing Agenda for Change and Very Senior Manager arrangements.

4.5 Senior Managers Service Contracts

	Start date	Unexpired term at 31.03.2014	Notice Period
Dr Ian Orpen, Chair of the CCG	01.04.2013	3 years	3 months
Dr Simon Douglass, Clinical Accountable Officer	01.04.2013	3 years	3 months
Dr Ruth Grabham, Clinical Director	01.04.2013	1 year	3 months
Dr Shan Mantri, GP Cluster Lead	01.04.2013	1 year	3 months
Dr Jim Hampton, GP Cluster Lead	01.04.2013	3 years	3 months
Helen Harris, Prectice Manager Cluster Lead	01.04.2013	3 years, 2 months	3 months
Roger Stead, Pracice Manager Cluster Lead	01.04.2013	None	
John Holden, Lay Member (Audit and Governance)	01.04.2013	3 years	3 months
Dr Mark Daly, Secondary Care Consultant	01.04.2013	None	
JP Sanders, Lay Member (Patient and Public Involvement)	01.04.2013	None	
Suzannah Power, Lay Member (Patient and Public Involvement)	01.02.2014	3 years, 10 months	3 months

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

4.6 Payments to past Senior Managers

During 2013-14 there were no redundancy 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.

4.7 Pension Benefits

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

4.7.1 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 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.

4.7.2 Real Increase in CETV

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

4.8 Salaries and allowances - subject to audit

	2013-14						
Name and Title	Salary and Fees (bands of £5,000)	Other Remuneration (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500) *see note	Total (bands of £5,000)
Dr Ian Orpen, Chair of the CCG	90-95					7.5-10	95-100
Dr Simon Douglass, Clinical Accountable Officer	95-100					(37.5)-(40)	55-60
Dr Ruth Grabham, Clinical Director	80-85					122.5-125	200-205
Tracey Cox, Chief Operating Officer	90-95					25-27.5	115-120
Sarah James, Chief Financial Officer	90-95					55-57.5	145-150
Dawn Clarke, Director of Nursing and Quality and Registered Nurse	70-75					75-77.5	145-150
Dr Shan Mantri, GP Cluster Lead	30-35	0-5				170-172.5	210-215
Dr Jim Hampton, GP Cluster Lead	30-35						30-35
Dr Elizabeth Hersch, GP Cluster Lead	30-35	10-15				125-127.5	165-170
Helen Harris, Practice Manager Cluster Lead	10-15						10-15
Roger Stead, Practice Manager Cluster Lead	0-5						0-5
John Holden, Lay Member (Audit and Governance) and Vice Chair	10-15						10-15
Dr Mark Daly, Secondary Care Consultant	5-10						5-10
JP Sanders, Lay Member (Patient and Public Involvement)	5-10						5-10
Suzannah Power, Lay Member (Patient and Public Involvement)	0-5						0-5

*In respect of the category "All Pension Related Benefits" the following should be noted:
This column shows the potential total benefit to the employee from the employer's pension contributions during the year, taking into account both the lump sum payable on retirement and an assumed period of 20 years for receipt of an annual pension.
Governing Body members with no details provided either did not contribute to the NHS Pension Scheme or their contributions were not paid via the employing organisation (not the CCG) in the case of staff who are recharged.
Figures for Dr Ian Orpen and Dr Simon Douglass include both officer and practioner benefits (see note to Pension Benefits Table).
Figures for Dr Ruth Grabham, Dr Shan Mantri and Dr Elizabeth Hersch include officer benefits only (see note to Pension Benefits Table).
Figures for Dr Ruth Grabham, Dr Shan Mantri and Dr Elizabeth Hersch show the increase since any previous period of work for BaNES PCT, which may have been a number of years pervi-ously.

The costs for Dr Jim Hampton were recharged by St Michael's Surgery and include the CCG's share of employer's National Insurance and Pension paid by the practice.
The costs for Helen Harris were re-charged by Number 18 Surgery and include the CCG's share of employer's National Insurance and Pension paid by the practice.
The costs for Roger Stead were re-charged by Fairfield Park Surgery and include the CCG's share of employer's National Insurance and Pension paid by the practice.
The figures under the category "Other Renumeration" for Dr Shan Mantri and Dr Elizabeth Hersch refer to the work for the CCG other than for Governing Body responsibilities.

4.9 Pension Benefits - subject to audit

	2013-14							
Name and Title	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2014 (bands of £0000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)	Cash equivalent transfer value at 31 March 2013 (£000)	Cash equivalent transfer value at 31 March 2014 (£000)	Real increase in cash equivalent transfer value (£000)	Employer's contribution to partnership pension (£000)
Dr Ian Orpen, Chair of the CCG	0-2.5	2-5.5	60-65	190-195	1,200	1,292	37	0
Dr Simon Douglass, Clinical Accountable Officer	0-(2.5)	0-(2.5)	50-55	150-155	873	902	(13)	0
Dr Ruth Grabham, Clinical Director	5-7.5	15-17.5	15-20	45-50	207	281	59	0
Tracey Cox, Chief Operating Officer	0-2.5	2.5-5	25-30	75-80	357	401	24	0
Sarah James, Chief Financial Officer	2.5-5	7.5-10	30-35	90-95	450	526	55	0
Dawn Clarke, Director of Nursing and Quality and Registered Nurse	2.5-5	10-12.5	15-20	45-50	241	325	70	0
Dr Shan Mantri, GP Cluster Lead	7.5-10	22.5-25	10-15	30-35	35	130	89	0
Dr Elizabeth Hersch, GP Cluster Lead	5-7.5	15-17.5	5-10	15-20	42	116	67	0

Dr Jim Hampton's pension contributions are paid via his practice - St Michael's Surgery and are recharged to the CCG, so the CCG is unable to disclose this detail.
Helen Harris' pension contributions are paid via her employing surgery - Number 18 and are recharged to the CCG, so the CCG is unable to disclose this detail.
Roger Stead's pension contributions are paid via his employing surgery - Fairfield Park and are recharged to the CCG, so the CCG is unable to disclose this detail.
Dr Mark Daly does not contribute to the NHS Pension Scheme for his CCG employment.
The figures for Dr Ruth Grabham, Dr Elizabeth Hersch and Dr Shan Mantri have been calculated on officer service (work undertaken for the CCG) only and do not take into account any of the practitioner benefits (work undertaken as a GP).
The figures for Dr Ian Orpen and Dr Simon Douglass are calculated on both officer and practitioner benefits accrued in the Pension Scheme. Therefore, the amounts include pension benefits accrued from employment other than that with the CCG, for example as a GP Partner and/or as a salaried GP.
Figures for Dr Ruth Grabham, Dr Shan Mantri and Dr Elizabeth Hersch show the increase since any period of previous work for BaNES PCT, which may have been a number of years previously.

4.10 Pay Multiples - subject to audit

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Governing Body member in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid Governing Body member in the CCG in the financial year 2013/14 was £90,000-£95,000. Based on a whole time equivalent this salary was in the band of £150,000-£155,000. This was 3.45 times the median remuneration of the workforce, which was £44,146.

In 2013/14, 0 employees received remuneration in excess of the highest-paid director. Full-time equivalent remuneration ranged from £17,000 to £153,000. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

4.11 Off-payroll Engagements

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

a) Off payroll engagements as at 31 March 2014, for more than £220 per day and that last longer than six months.

Number of existing engagements as of 31st March 2014	3
Of which, the number that have existed:	
for less than one year at the time of reporting	3
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four years or more at the time of reporting	0

All existing off-payroll engagements outlined above 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.

d) For all new off payroll engagements between 1 April 2013 and 31 March 2014, for more than £220 per day and that last longer than six months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014.	4
Number of new engagements which include contractual clauses giving the CCG the right to request assurance in relation to income tax and National Insurance.	0
Number for whom assurance has been requested.	4
Of which:	
assurance has been received	4
assurance has not been received	0
engagements terminated as a result of assurance not being received, or ended before assurance received	0

e) For any off payroll engagements of board members and or senior officials with significant financial responsibility between 1 April 2013 and 31st March 2014.

	Number
Number of engagements of board members and senior officials with significant financial responsibility during the year.	3
Number of individuals that have been deemed 'Board Members and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both off-payroll and on-payroll engagements.	15

Note: The three off payroll engagements relate to members of the Governing Body who are either partners in or employees of GP Practices, and for whom the payment mechanism agreed is to reimburse the practice for the cost of their time rather than paying them directly through the CCG's payroll. One of these exceptional engagements lasted for the full year and another for 10 months, and both are ongoing. The third engagement lasted one month. The CCG is in the process of reviewing the payment mechanisms for each Governing Body member to ensure that all represent the most effective and appropriate arrangement.

4.12 Membership Body and Governing Body Profiles

Dr Ian Orpen – Chair of the CCG and member of the Remuneration and Nominations Committee since April 2013.

Ian has been a GP in Bath since 1989 and at St James's Surgery since 1991. He worked as a GP Specialist in Orthopaedics for 15 years and as a GP Trainer for 12 years. This range of exposure to the health service has given him an insight into the problems and potential solutions locally. Faced by financial pressures and an aging population with more complex and costly care required, Ian feels that working with the CCG is an opportunity for him to contribute to ensuring we maintain high quality healthcare for the population of BaNES.

Dr Simon Douglass – Clinical Accountable Officer, member of the CCG Board, Quality Committee and Chair of the Operational Leadership Team since April 2013.

Simon has been a GP since 1994 at Hope House Surgery in Radstock. As well as finding the face-to-face contact with his patients in the local community very rewarding, Simon also relishes the challenge of helping to shape and improve the quality of health services for the whole of the BaNES population.

Dr Ruth Grabham – Clinical Director and GP Cluster Commissioning Lead Board Member (Bath East), member of the Quality Committee and Operational Leadership Team since April 2013.

Ruth qualified from Charing Cross Medical School in 1987 and became a partner at Newbridge Surgery, Bath, in 1993. Since then she has also set up and chaired the local out-of-hours service and worked at the RUH as a cardiology clinical assistant. Ruth sees that clinicians being involved more closely in commissioning will deliver real benefits to patients. By harnessing the expertise and knowledge from working with patients, Ruth believes the CCG can work collaboratively with providers and the community, to improve the way services are delivered to patients in these challenging financial times.

Dr Jim Hampton – GP Cluster Commissioning Lead Board Member (Bath Central), member of the OLT and Individual Patient Panel since April 2013.

Jim qualified from Charing Cross in 1980 and has been a GP in Twerton and Southdown since 1990. His clinical interests include orthopaedics and sport medicine, and he also covers Bath rugby as one of the pitch-side doctors. Jim believes that the establishment of the CCG puts clinicians back at the heart of developing services for patients, and gives us the best chance of maintaining quality NHS services locally, through best use of the resources we have available.

Dr Elizabth Hersch – GP Cluster Commissioning Lead Board Member (Midsomer Norton & Radstock) and member of the OLT since April 2013.

Elizabeth graduated from Bristol University in 1993 and completed her GP training in 1997. She has been a GP Principal at St Chads Surgery, Midsomer Norton, since 2001. Elizabeth's clinical interests include Women's Health and Dermatology. Over the past few years she has been a member of the Practice Based Commissioning Executive, Urgent Care Network, Medicines Management Group and has been a Board member of the CCG since its inception. Elizabeth sees the development of the CCG as a challenging but great opportunity to ensure clinically-led, excellent, sustainable patient-centred services. This requires the responsibility and involvement of the whole health community with an emphasis on prevention, innovation and positive relationships.

Dr Shan Mantri – GP Cluster Commissioning Lead Board Member (Chew Valley & Keynsham) and member of the OLT since April 2013.

Shan qualified from Kings College London in 2001 and finished his GP training in 2009 after spending two years working in the RUH and a year at St James's Surgery, Bath. Having spent five years working as a freelance/ sessional GP in the Bath/Wiltshire area he is now a partner at Newbridge Surgery, Bath.

Dawn Clarke – Director of Nursing and Quality and Registered Nurse Board Member, Chair of the Individual Patient Panel, member of the Quality Committee and Operational Leadership Team since April 2013.

Dawn qualified as a registered nurse from the University Hospital of Wales in 1984 and since then has held a range of roles in the NHS, most recently in NHS North West. She is passionate about improving patient safety and quality of care and enjoys working with service users, the public, clinicians and partners in other agencies and organisations on this. Dawn does not underestimate the challenges for the CCG in commissioning high quality, safe services for local residents and she is delighted to be working with BaNES CCG as it seeks to positively improve the environment of care for the patient and promote quality care for all.

JP Sanders – Lay Member of the Board (Patient and Public Involvement), Chair of the Quality Committee, member of the Audit Committee and Remuneration and Nominations Committee from April to December 2013.

JP has experience of both the public and private sectors, gained from local government to the travel sector. He has been a Customer Service Director in local authorities in Devon and Gloucestershire and worked in Plymouth on delivering long-term solutions for health and social care priorities. JP was pleased to represent BaNES patients on the CCG to ensure the delivery of the best possible healthcare, focused around the priorities and needs of local patients.

Suzannah Power – Lay Member of the Board (Patient and Public Involvement), Chair of the Quality Committee, member of the Audit Committee and Remuneration and Nominations Committee since February 2014.

Suzannah has worked in a range of customer-focused roles in the private, public and voluntary sector. She was Patient Representative on the British Heart Foundation Council from 2007–2013 and has worked on several NICE guidelines, including Patient Experience in Adult NHS Services. She sits on the Royal College of Physicians' Academic Medicine Committee and on the Research for Patient Benefit South West Region Funding Committee, ensuring that clinical research has the patient viewpoint at its very centre. Suzannah's interests include developing meaningful community engagement and shared decision-making. She is a passionate advocate for patients becoming active partners in their own healthcare.

John Holden – Lay Member of the Board (Audit and Governance) and Vice Chair, Chair of the Audit Committee and Remuneration and Nominations Committee since April 2013. Chair of the Quality Committee between December 2013 and January 2014.

John has a degree in Natural Sciences and Law from Cambridge and a first career with BP. He then enjoyed two three-year terms as CEO of Companies House and Registrar of Companies before taking up non-executive director appointments and serving as alternate chair of audit with the Passport Agency, the Criminal Records Bureau and the Independent Police Complaints Commission. John was a non-executive director with Wiltshire PCT (latterly NHS BaNES and Wiltshire) and chair of their audit committee for the period 2006-13. His focus as a non-executive has been to help secure the best possible healthcare for our local population and best possible value for money for the taxpayer. The need for that twin focus has never been greater.

Dr Mark Daly – Secondary Care Consultant Board Member, member of the Quality Committee, Audit Committee and Individual Patient Panel since April 2013.

Mark works as a Consultant Physician in Exeter and his specialist fields include diabetes, obesity and acute medicine – the emergency management of people with medical as opposed to surgical treatments. Mark also works as a clinical director in Exeter, where he is aiming to raise the experience of urgent hospital care to that of planned care. Emergency patients are vulnerable and, because things are unpredictable at individual level, the patient's experience can sometimes feel chaotic, but Mark believes that can change. Mark trained in the North-East of England (and briefly Paris).

Tracey Cox – Chief Operating Officer and Board Member, and member of the OLT since April 2013.

Tracey has worked within BaNES in the commissioning of healthcare services since 2001 and prior that at the RUH, Bath, managing general surgery and orthopaedic services. She joined the health service in 1990 as a management trainee after graduating from Goldsmith's College, University of London and worked in several London hospitals managing different specialities prior to moving to the South West in 1997. The development of the CCG, and working very closely with GPs and other clinicians, creates new opportunities to look at the way we commission local health and social care services and communicate and engage with local people.

Sarah James – Chief Financial Officer and Board Member, and member of the OLT since April 2013.

Sarah joined the NHS in 1987 as a finance trainee after graduating from the University of Surrey and qualified as a Chartered Public Finance Accountant in 1993. She has since worked in a number of NHS provider and commissioner organisations in BaNES and the South West, joining BaNES PCT in 2009. She has worked with the CCG since it was set up in shadow form in April 2012. Sarah believes that the strength of GP involvement in commissioning locally and the unique way in which we work with B&NES Council give a really sound basis for the CCG to tackle the challenges we face.

Helen Harris – Practice Manager Cluster Commissioning Lead Board Member (Bath West), member of the OLT since June 2013

Helen has worked for the NHS since 1997, and has been Practice Manager at Number 18 Surgery in Bath since 2001, representing BaNES Practice Managers on a number of committees. Prior to this Helen worked in retail management for a very customer-focused company. She feels that patient engagement, communication and involvement are key to commissioning good patient services and care for the local community.

Roger Stead – Practice Manager Cluster Commissioning Lead Board Member (Bath East), member of the OLT for April 2013.

Since graduating from Bath University in 2000 Roger has held a range of roles in the NHS. He has worked with GP practices for Bristol North PCT including Fishponds, Eastville and Easton, and has also set up services for asylum-seekers and homeless people. Roger has been Practice Manager at Fairfield Park Health Centre for over six years and has represented BaNES Practice Managers on a number of committees.

4.12.1 Board Members Register of Interests 2013/14

Ian Orpen, Chair	• Partner St James's Surgery, Bath – Member Practice • Part Shareholder, Bath Community Pharmacy • Practice is a member of BARONET (Bath Area Research Network) • Family member works for Sirona Care & Health • Relative is Board Member of UHB • Practice Partner at Surgery is CEO of BEMS (Bath Emergency Medical Services) • Stakeholder Governor on the RUH Bath NHS Shadow Trust's Council of Governors
Simon Douglass, Clinical Accountable Officer	• Salaried Principal, Hope House Surgery, Radstock – Member Practice (previously senior partner) • Family member works for Somerset Partnership Trust
Ruth Grabham, Clinical Director	• Partner, Newbridge Surgery, Bath – Member Practice • Relative is Partner at Beachcroft Solicitors • Acquaintance is Partner of Xcetra Graphic Design Company
Elizabth Hersch, GP Cluster Commissioning Lead	• Partner, St Chad's Surgery, Midsomer Norton – Member Practice • Shareholder, Bath Community Pharmacy • Family member is Consultant Anaesthetist at RUH, Circle Bath and BMI Bath
Jim Hampton, GP Cluster Commissioning Lead	• Partner, St Michael's Surgery, Bath – Member Practice • Director of Kelston Treatment Services – medico legal company • Director Bath Pharmacy Company Internet Pharmacy (within practice)
Shan Mantri, GP Cluster Commissioning Lead	• GP, Newbridge Surgery – Member Practice • Locum/Freelance GP • Sulisdoc Committee Member (local sessional GP Group) • Family member is Locum/Freelance GP
Sarah James, Chief Financial Officer	• Branch Treasurer, SW Branch Healthcare Financial Management Association
Tracey Cox, Chief Operating Officer	• Nil
John Holden, Lay Member (Audit and Governance) and Vice Chair	• Non-Executive Director of NHS BaNES and Wiltshire Cluster with transitional responsibilities
Suzannah Power, Lay Member, (Patient and Public Involvement)	• Panel member, South West Regional Funding Committee for the National Institute for Health Research (NIHR) and Research for Patient Benefit (RfPB) • Honorary Panel member on the Academic Medicines Committee of the Royal College of Physicians • Family member is a GP Representative on the Wiltshire CCG. • Family member is a GP in Wiltshire
John Paul Sanders, Lay Member, (Patient and Public Involvement)	• Nil
Mark Daly, Secondary Care Consultant	• Nil
Dawn Clarke, Director of Nursing and Quality and Registered Nurse	• Nil
Helen Harris,Practice Manager Cluster Commissioning Lead	• Practice Manager, Number 18 Surgery – Member Practice
Roger Stead, Practice Manager Cluster Commissioning Lead	• Practice Manager of a BaNES GP Surgery – Fairfield Park Health Centre (FPHC)

Simon Douglass, Clinical Accountable Officer
5 June 2014

Statements by the **Accountable Officer**

5 Statement of Accountable Officer's Responsibilities

Statement of the Clinical Accountable Officer's Responsibilities as the Accountable Officer of BaNES CCG.

The NHS Act 2006 states that each CCG shall have an Accountable Officer and that officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Simon Douglass to be the Accountable Officer to the BaNES CCG.

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

Under the NHS Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year financial statements in the form and on the basis set out in Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health and in particular to:

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

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

Simon Douglass
Clinical Accountable Officer
5 June 2014

6 Governance Statement

6.1 Introduction and Context

The CCG was licensed from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the NHS Act 2006.

The CCG operated in shadow form prior to 1 April 2013, to allow for the completion of the licensing process and the establishment of function, systems and processes prior to the CCG taking on its full powers. As at 1 April 2013, the CCG was licensed without conditions.

6.2 Scope of Responsibility

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

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

6.3 Compliance with the UK Corporate Governance Code

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

6.4 The CCG Governance Framework

The NHS Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it. The Governing Body, known locally as the Board, is responsible for strategic leadership, policy making and overall performance. The Board is made up of a Clinical Chair; members of the executive team, who are the Clinical Accountable Officer, Chief Operating Officer, Chief Financial Officer and Director of Nursing and Quality; the Clinical Director and three GP Cluster Commissioning Leads; and a Practice Manager Cluster Commissioning Lead. In addition there are two lay representatives, one of whom is the Vice Chair of the Board; and a secondary care specialist doctor. The Director of Nursing acts as the registered nurse representative. The Board has overall responsibility for all decisions not reserved to the Council of Members.

All practice members of the CCG are represented on the Council of Members. The members have responsibility for approving the arrangements for appointing practice representatives and clinical leaders to the Board; approving the strategic direction and commissioning plans of the CCG; and approving the Annual Report and Accounts. The area of the group is divided into five Clusters: Norton Radstock; Chew/Keynsham; Bath East; Bath West; and Bath Central.

See Figure 1 for Board meeting attendance.The Board has appointed the following committees, all of which are accountable to the Board.

6.4.1 Audit Committee

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

The membership of the Audit Committee comprises: the lay member with responsibility for governance and audit, who chairs the Committee; the lay member with responsibility to lead on public and patient participation matters; the secondary care specialist doctor. The Chief Financial Officer and the Clinical Accountable Officer generally attend meetings, together with representatives from internal and external audit and counter fraud. See Figure 1 for Committee meeting attendance.

6.4.2 Remuneration and Nominations Committee

This Committee makes recommendations on determination of the remuneration, fees and other allowances for employees and for people who provide services to the CCG and on determination of allowances under any pension scheme that the CCG may establish as an alternative to the NHS pension scheme. This Committee also considers severance payments of senior employees and monitor and evaluate the performance of members of the Board.

The membership of the Remuneration and Nominations Committee comprises: the lay member with responsibility for governance and audit, who chairs the Committee; the lay member with responsibility to lead on public and patient participation matters; the Chair of the CCG. An HR specialist from CSCSU is always in attendance at meetings. See Figure 1 for Committee meeting attendance.

6.4.3 Quality Committee

This Committee provides assurance on the quality of services commissioned, providing a culture of continuous improvement and innovation with respect to patient safety, clinical effectiveness and patient experience. In addition this Committee ensures there are robust systems in place to safeguard adults and children; monitors arrangements to ensure compliance with equality and diversity obligations; ensures delivery of requirements for information governance; ensures systems are in place to support the governance of research; and receives, reviews and scrutinises reports on Serious Incidents and Never Events occurring in commissioned services.

The membership of the Quality Committee comprises: the lay member with responsibility to lead on public and patient participation matters, who chairs the Committee; the registered nurse on the Board who is the Director of Nursing and Quality; the secondary care specialist doctor; two GP members on the Board; the Clinical Accountable Officer; a public health consultant and two patient representatives from the Patient and Public Engagement Group. See Figure 1 for Committee meeting attendance.

6.4.4 Operational Leadership Team

This Committee provides the operational delivery of agreed strategy, including strategic commissioning intentions. In addition, this Committee oversees the effective delivery of commissioning support services to the CCG; manages the overall communication and consultation process for the CCG; leads on organisational development and the development of primary care strategy.

The membership of the OLT comprises: the Clinical Accountable Officer, who chairs the Committee; the Chief Financial Officer; the Chief Operating Officer; the Clinical Director; the Director of Nursing and Quality; three GP Cluster Commissioning Leads and the Practice Manager Cluster Commissioning Lead and the Strategic Director for People and Communities (or deputy). See Figure1 for Committee meeting attendance.

6.4.5 Individual Patient Panel (known as the Individual Funding Request Panel)

This Committee is responsible for considering the case for exceptional funding for individual patient treatment and monitoring the trends in individual patient treatment requests and making policy recommendations to the Board.

The members of the Individual Patient Panel (IFR) comprise: the registered nurse on the Board who is the Director of Nursing and Quality, who chairs the Committee; the secondary care doctor specialist; a lay member; and two GP members. See Figure 1 for Committee meeting attendance.

6.4.6 Other

In addition, the Group has entered into joint arrangements with the following organisations:

- NHS Wiltshire CCG
- B&NES Council in relation to section 75 agreements

The Joint Committee for the Oversight of Joint Working has been established to oversee the joint commissioning arrangements with B&NES Council.

Figure 1 - Meeting Attendance 2013/14

Member	Title	Board	Audit Committee	Remuneration and Nominations Committee	Quality Committee	Operational Leadership Team	Individual Patient Panel
Dr Ian Orpen	Chair of the CCG	8/9		2/2			
Dawn Clarke	Director of Nursing and Quality and Registered Nurse	9/9			5/6	10/12	11/11
Tracey Cox	Chief Operating Officer	8/9				12/12	
Dr Mark Daly	Secondary Care Consultant	6/9	0/5		1/6		0/11
Dr Simon Douglass	Clinical Accountable Officer	9/9			0/6	10/12	
Dr Ruth Grabham	Clinical Director	9/9			6/6	9/12	
Dr Jim Hampton	GP Cluster Commissioning Lead	4/6				10/12	8/11
Helen Harris	Practice Manager Commissioning Lead	6/6				7/10	
Dr Elizabeth Hersch	GP Cluster Commissioning Lead	5/9				8/12	
John Holden	Lay Member (Audit and Governance) Vice Chair	9/9	5/5	2/2	2/2		1/11
Sarah James	Chief Financial Officer	8/9				8/12	
Dr Shan Mantri	GP Cluster Commissioning Lead	8/9				9/12	1/11
Suzannah Power	Lay Member (Public and Patient Involvement)	2/2	0/1	2/2			
JP Sanders	Lay Member (Public and Patient Involvement)	4/6	3/4		1/4		
Roger Stead	Practice Manager Commissioning Lead	2/2				0/1	
B&NES Council People and Communities Representative						6/6	
Public Representative					3/6		
Patient Representative					2/6		
Healthwatch Representative					2/6		

6.4.6 Board Performance and Effectiveness

The first year of the CCG has seen the Board meet in public on eight occasions and make a number of key decisions that will have significant impact on the services provided in the area and have tested us a Board in the process. The commissioning of the integrated Urgent Care Centre at the RUH Emergency Department, along with GP Out of Hours and Homeless services will shape urgent care services for the future and required careful governance in dealing with potential conflicts of interest. Working with B&NES Council we have decided to put the integrated health and social care community services out to tender, but with a contract of up to seven years. The board has also demonstrated its determination to work with providers to ensure safe, high quality services are delivered for the patients and public such as the challenging launch of the NHS 111 service. This was supported by arranging two joint board meetings with co-commissioners Wiltshire CCG.

During 2013/14, the Board has engaged in a programme of review of its functioning. Specifically, the Board has used the bi-monthly seminar programme for a mix of development and training sessions for members; for example safeguarding training, developing strategy and reviewing its performance. The Board also requested changes to the CCG Constitution to improve effectiveness through revised Committee Terms of Reference and to address quoracy issues.

6.4.7 Council of Members Performance and Effectiveness

The Council of Members met once immediately before the start of the year on 28th March 2013 to approve the CCG's initial medium term operational and financial plan, and has met twice during the year on 10th December 2013 to receive an interim report from the CCG and on 27th March 2014 to approve the CCG's draft 5 Year Strategic and 2 Year Operational Plans for the period beginning 2014/15. During this first year of operation the Council of Members were not required to approve an Annual Report and Accounts. Attendance at meetings was in the range of 80-85%, and with proxy attendances between 90 and 95%.

6.4.8 Highlights of Committee Reports

6.4.8.1 Audit Committee

The Audit Committee has focused on the establishment and maintenance of effective systems of integrated governance, risk management and internal control; and other appropriate assurance systems during the first year. This has included leading the development of a Board Assurance Framework and establishing effective risk management arrangements, which were complimented by the internal auditors. The Committee has kept under review the progress being made to the CCG to establish an appropriate policy framework and has approved financial policies and delegated financial limits. The Committee has also determined the internal and external audit workplans for the first year of the CCG's operation and reviewed audit findings and monitored delivery of action plans, including those remaining as a legacy from the PCT.

6.4.8.2 Remuneration and Nominations Committee

The Remunerations and Nominations Committee has discussed the pay arrangements for various senior members of the CCG team.

6.4.8.3 Quality Committee

The Quality Committee has led the development of the CCG's Quality Strategy and delivery plan, updating these to align with the 5 Year Strategic Plan. The Committee has also led the development of monthly Quality and Patient Experience reporting, bringing together information from complaints, patient surveys, incidents and the Friends and Family Test to highlight both good practice and emerging themes requiring action. The Committee has overseen the development of collaborative working with other organisations on quality, safeguarding, healthcare acquired infection reduction, and the use of Commissioning for Quality and Innovation (CQUIN) schemes,

6.4.8.4 Operational Leadership Team

The OLT has responsibility for the day-to-day performance of the CCG and regular agenda items include analysis of the monthly performance and finance reports and review of the risk register, this latter includes a more detailed assessment and review of all risks on a quarterly basis.

Highlights of the Committee's work in the first year include review and analysis of our enhanced service for nursing home support, agreeing a service specification and pilot for a referral management service and setting in train a service redesign for incontinence services. The OLT has settled into an effective operational management forum for the CCG.

6.4.8.5 Individual Patient Panel

The Individual Patient Panel meets monthly to consider the case for exceptional funding for individual patient treatment requests; it also monitors trends and makes policy recommendations in the light of this to the Board, via the OLT. In the past year, the process overseen by the Panel has benefitted from a thorough review and the introduction of new procedures and supporting arrangements, improving timeliness and control and enhancing decision-making. The Panel also ensures compliance with emerging legal requirements and oversees the update of policies on individual treatment areas.

6.5 The CCG Risk Management Framework

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

The CCG is required to have in place an assurance framework that will enable the Board to be confident that the systems, policies and people they have put in place are operating in a way that is effective, is focused on key risks and is driving the delivery of objectives. The CCG has such a framework in place. The assurance framework outlines the systems in place to manage delivery of the organisation's strategic objectives and control the risks to those objectives. It details where assurances on the effectiveness of the system can be obtained, where there are gaps in assurance or control and any actions required to strengthen assurance or control.

During the year gaps in both controls and assurance were identified through the management of the assurance framework. Work took place to address the identified gaps through agreed controls and the monitoring of their implementation. The identified gaps were reduced throughout the year with progress reported regularly to the Audit Committee and the Board. At the Year End no significant actions remained outstanding although in some instances interim controls were applied until full delivery of the actions in 2014/15.

The Risk Management Strategy describes the organisational responsibilities for risk management, the role of all managers and clinicians and the involvement of all staff in the ownership of, and commitment to, reducing risks. The strategy sets out the CCG's strategic direction for the management of risks and provides the framework for the continued development of risk management processes throughout the CCG. The strategy covers in detail the following areas:

- Strategic objectives for risk management
- Risk management framework and approach
- Roles and responsibilities
- Risk management process
- Risk identification, assessment and measurement
- Risk appetite
- Risk reporting and monitoring

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

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

The Board and the Quality Committee are involved in setting priorities and monitoring progress for Equality, Diversity and Human Rights. The CCG has a robust recruitment and selection process to support a fair recruitment process. The focus of work for patients and the public is commissioning for quality, delivering the highest quality care for all. Quality and Commissioning teams ensure that patient experience and feedback are central parts of service design and delivery. The CCG undertook an engagement process related to 'Call to Action' in the Autumn and has recently commenced a programme of engagement in relation to the development of our 5 Year Strategic Plan. The Joint Strategic Needs Assessment (JSNA), which is an evolving description of the needs of our population, relates to everyone who lives or works in BaNES. Equality and diversity permeates this document to increase social inclusion, reduce inequalities and give local communities the opportunity to shape services.

The CCG undertakes equality impact analysis as an integral part of reviewing and developing service specifications, and all committee papers require consideration of the equality impact of the subject matter.

Members of staff have received briefings regarding fraud and their role in helping to prevent fraud within the organisation. Training in risk management was provided for senior commissioners and directors during 2013/14.

6.6 The CCG Internal Control Framework

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

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

6.6.1 Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information

governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for the reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

6.6.2 Pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

6.6.3 Equality, Diversity and Human Rights Obligations

Control measures are in place to ensure that the CCG complies with the required public sector equality duty set out in the Equality Act 2010.

A compliance report was presented to the Board in January 2014.

6.6.4 Sustainable Development Obligations

The CCG is required to report its progress in delivering against sustainable development indicators.
We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaption objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure the CCG complies with its obligations under the Climate Change Act 2008, including the Adaption Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

6.7 Risk Assessment in relation to Governance, Risk Management and Internal Control

The CCG is required to have in place an Assurance Framework which will enable members of the Board to be confident that the systems, policies and staff they have put in place are operating in a way that is effective and is focused on the delivery of organisational objectives. The CCG Board formally adopted an Assurance Framework for 2013/14 and has reviewed it throughout the year.
The Audit Committee is responsible for monitoring the Assurance Framework and recommends it to the Board. The Board reviewed the Assurance Framework on five occasions during 2013/14. The Assurance Framework details:

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

The arrangements for accountability and responsibility
The CCG has an organisation-wide risk register that covers the risks identified and provides risk analysis. In addition, the CCG has identified the risks associated with the Strategic Objectives outlined within the CCG Assurance Framework and covers the following aspects of risk:

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

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

Executive directors are fully engaged with the system to maintain and update the Board Assurance Framework and Risk Register.

Risks are systematically identified, evaluated and controlled by each Directorate within the CCG. Significant risks are identified and reported in the organisation-wide Risk Register.

The risk profile of the CCG is represented in a Partnership Risk Map which is reviewed by the Audit Committee and the OLT.

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 the agenda.

Significant risks in 2013/14 associated with delivery of service plans have included concerns about management of the urgent care system, including the delivery of the four hour waiting time targets, mixed sex accommodation breaches, ambulance performance, issues associated with the future of the Royal National Hospital for Rheumatic Diseases and plans associated with the establishment of an Urgent Care Centre at the RUH. Concerns related to the delivery of the NHS 111 service have continued to feature as a risk in 2013/14. Financial risks have included performance of the Independent Sector Treatment Centre contract and concerns related to the contractual arrangements of Continuing Healthcare Patients. Quality risks have included performance related to health acquired infections and issues related to patient communications between healthcare providers. Risks linked to capacity and capability have focused on the delivery of commissioning support services, the communications support received via a service level agreement from Wiltshire CCG and engagement with local GPs.

6.8 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 OLT and Board review performance including quality, productivity and financial aspects at every meeting.

The CCG uses benchmarking and other comparative data, procurement and market testing, and individual service review to test the value for money of commissioned services. Where services are determined not to be providing good value, improvement plans are implemented. This is underpinned by the CCG's strategic planning approach, which recognises continuous testing of value for money, and taking action to release resources that are not being used to best effect, as essential to successful commissioning.

Internal Audit considers value for money in their reviews and where appropriate makes recommendations to improve data quality, effectiveness, efficiency and productivity.

6.9 Review of the effectiveness of Governance, Risk Management and Internal Control

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

6.9.1 Capacity to handle risk

The Board, the Audit Committee, the OLT, the Clinical Accountable Officer and the executive directors provide leadership to the risk management process. The Risk Management Strategy details the responsibilities of staff. Training in risk management was provided for senior commissioners and directors during 2013/14. The risk management systems have been audited recently with positive assurance provided. Recommendations for further enhancement are being implemented.

6.9.2 Review of effectiveness

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

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Quality Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place. The Board has contributed to the effectiveness of the system of internal control by approving and reviewing the Board Assurance Framework and Risk Register and receiving reports from committees. The Board receives progress reports on the achievement of the strategic and corporate objectives as part of the regular performance review. The Board reviews financial, service delivery and quality performance at every meeting and receives periodic reports regarding delivery of statutory and other obligations including in relation to: the public sector equality duty; partnership responsibilities, in particular to develop joint health and wellbeing strategies; securing

public involvement ; delivery of the NHS Constitution; securing continuous improvement in the quality of services.

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

The Audit Committee has reviewed progress in the establishment of an appropriate policy framework for the CCG during 2013/14. The Audit Committee has also received reports regarding the progress of internal and external audit and counter fraud and reviewed best practice guidance relating to governance arrangements. The Audit Committee has received audit reports and monitored action plans in relation to these. The Audit Committee will review their performance early in the new financial year and has provided an annual report for the Board.

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

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

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

Our opinion is based solely on work we have completed to assess whether the controls in place support the achievement of management's objectives as set out in our Individual Assignment Reports, but our opinion does not take into account the results of any internal audit or other assurance work conducted in relation to the CSU or other service organisations.

We have completed the programme of internal audit work for the year ended 31 March 2014. Our work identified low, medium and high rated findings. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and/or effectiveness of governance, risk management and control.

The key factors that contributed to our opinion are summarised as follows:

- *The overall classification of the following reports was high risk:*
  - *(a) Business Continuity Planning, which included two high risk findings relating to undertaking a business impact analysis, and the resources to create a robust business continuity management capability*
  - *(b) Information Governance arrangements, which included three high risk findings in relation to information governance policies, classification of information assets, and clarity around information governance roles*
  - *(c) Commissioning Support Unit (CSU) – contract monitoring and performance report, which included two high risk findings in relation to provider performance support, and key performance indicators for IT and*
  - *(d) Continuing Healthcare/ Funded Nursing Care, which included one high risk finding in relation to the processing of complex CHC cases*
- *We identified one high risk finding in our review of the QIPP process, which related to identifying and monitoring QIPP schemes*
- *We identified one high risk finding in our review Service Level Agreements, which related to the unsigned contracts*

However, we understand that, as the information governance review, commissioning support unit review, QIPP review, and contract management review, were undertaken early in the year, the CCG has taken action to address the high and medium risk rated findings raised.

Internal Audit have confirmed that the conclusion of 'some risk that management's objectives may not be fully achieved' is consistent with a reasonable level of assurance in respect of controls. During the year Internal Audit issued the following audit reports with a conclusion of high risk:

Audit Area	High Risk Issues	Actions Agreed	Actions Taken
Business Continuity Planning	Insufficient staffing resource to complete business continuity capability work	Appropriate staffing resource to be allocated	Action completed
	Incomplete Business Impact Analyses	Business Impact Analysis template to be revised and completed for all areas	Revised schedule for completion agreed and being implemented
Information Governance	Policy update and revision not completed	Updated policies to be approved	Action completed
	Lack of clarity between CCG and CSU roles	Roles and responsibilities to be confirmed	Action completed
	Information Asset Register not developed	Register to be developed	Register created and largely populated
CSU Contract Monitoring and Support	Lack of clarity on CSU provider performance process and reporting	Clear guidance to be provided and reporting developed	Action completed
	Lack of KPIs for Information Technology	KPIs to be developed	Action completed
Continuing Healthcare/Funded Nursing Care	Instances of best practice guidance not being followed in full and timescales not being met	Guidance to be followed in full and factors causing delay to be identified and managed	Action on guidance completed. Delay factors under investigation.

The two recommendations relating to high risk findings in lower risk reports, referenced in the Head of Internal Audit Opinion, have also been completed. The CCG identified areas of high risk at the beginning of its first year of operation, and targeted Internal Audit resource at these areas to ensure mitigating actions were identified and implemented at an early stage. The pattern of a number of high risk findings which have been addressed promptly reflects this.

The CCG procures a number of support services from CSCSU, who have undertaken Service Auditor Reporting in respect of these services to provide assurance to customers. The resulting reports have identified a small number of areas where the Service Auditor has issued a qualified opinion, which indicates that there was insufficient assurance on the design or operation of controls. The exceptions identified may relate to any customer of the CSU and are not specifically linked to the CCG.

Audit Area	Area of Qualified Opinion	CSU Response	CCG Response
Information Technology	There was no evidence that a data backup failure was investigated or remedied, and restoration tests were not carried out	We have now put additional controls in place to ensure this will not recur	Action completed
	The fire control systems in place for the data centre did not meet the description in the control objective, and there was no evidence of some monitoring of protection systems	We should have defined the control more accurately Controls to monitor protection systems have now been implemented	CSU have confirmed the controls which are in place Action completed
Payroll	One instance of a new starter form authorised by a staff member not on the authorised signatory list	Lists are being reviewed and updated and staff are being reminded of the requirement for a signature from the approved list	Appropriate response being implemented
	Authorisation for one advance payroll payment was made verbally	Our staff have been reminded of the requirement for a signature from the approved list	The CCG does not authorise payroll advances
Contract Manage-ment	There were instances of no evidence of timetabled meetings, negotiation strategy, or minutes relating to the contracting round	We believe these existed informally but were unable to provide auditable evidence	We are satisfied that this is an issue of lack of evidence, as local meetings were held as required
	There was no evidence that unsigned agreements were chased to the agreed timescale, and some lack of evidence held by the CSU of contract content	For the chosen sample the evidential email had been deleted. We were not precise enough in defining our controls to exclude contracts not managed by the CSU	We are satisfied that this is an issue of lack of evidence and imprecise control description, as local actions meet the appropriate standards
	Some contracts were not held on the intelligent contracting system or not held by CSU	We overstated the level of development of the system	We are satisfied that the CSU holds local contracts appropriately
	Regular contract monitoring meetings did not always take place	Where meetings were cancelled or did cover every issue we were unable to provide sufficient other evidence that control had been maintained	We are satisfied that this is an issue of lack of evidence, as locally there are supporting arrangements to maintain control
	There was insufficient evidence in some instances of review of provider invoices, or of the respon-sible party	We did not allow for the fact that CCGs check some of their own invoices, and had difficulty evidencing the population of in-voices which were our responsibility	We believe there are compensating controls as all payments are authorised by CCG budget holders
Financial Reporting	There was one instance of no evidence that CCG and CSU staff met to review and agree monthly financial information	Review and agreement took place but there was no documented evidence.	We believe there are compensating controls as the CCG does not report monthly information until satisfied of accuracy

6.9.3 Data Quality

The CCG has developed a robust process for assuring data quality with its providers as part of its contractual mechanisms. Key metrics pertaining to quality of provider data, such as NHS number, are monitored on a routine basis by the CSU along with progress against priorities in each provider's Data Quality Improvement Plan. Variances are highlighted to providers for rectification and followed up through routine meetings to ensure accurate and reliable provider data.

This ensures that data relied on by the Board and Council of Members is of sound quality to support performance management and decision making.

6.9.4 Business Critical Models

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

6.9.5 Data Security

The CCG has submitted a satisfactory level of compliance with the Information Governance Toolkit assessment, obtaining Level 2, with the exception of three elements relating to Information Assets Registers, where Level 1 was achieved, due to work not having been fully completed.

The CCG had one breach of data security during 2013/14. This lapse of data security was reported immediately to the Information Commissioner and has been confirmed by recent guidance as being at severity 0 (minor breach). The Information Commissioner was satisfied with actions taken by the CCG.

6.9.6 Discharge of statutory Functions

During establishment, the arrangements put in place by the CCG and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with all the relevant legislation. That legal advice also informed the matters reserved for Council of Members and Board decision and the scheme of delegation.

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

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

6.10 Conclusion

No significant internal control issues have been identified.

Simon Douglass
Clinical Accountable Officer
5 June 2014

Annual **Accounts**

7 External Audit Opinion

Independent auditor's report to the members of Bath and North East Somerset Clinical Commissioning Group

We have audited the financial statements of Bath and North East Somerset Clinical Commissioning Group (CCG) for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

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

- the table of salaries and allowances of senior managers and related narrative notes
- the table of pension benefits of senior managers and related narrative notes
- the details of pay multiples and related narrative notes.

This report is made solely to the members of Bath and North East Somerset CCG in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)'s members and the CCG as a body, for our audit work, for this report, or for opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report which comprises; the member practice introduction, the strategic report, the members report and the remuneration report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Bath and North East Somerset CCG as at 31 March 2014 and of its net operating costs for the year then ended; and
- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion: the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and

- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England's Guidance;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and
- locally determined risk based-work on the arrangements in place to implement the Better Care Fund.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of Bath and North East Somerset CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

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

Hartwell House | 55-61 Victoria Street | Bristol | BS1 6FT

6 June 2014

8 Annual Accounts for the Year to 31 March 2014

Contents

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4	2,455
Other costs	5	215,697
Other operating revenue	2	(3,973)
Net operating costs before interest		**214,179**
Other operating revenue		-
Other (gains)/losses		-
Finance costs		-
Net operating costs for the financial year		**214,179**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**214,179**
Of which:		
Administration Costs		
Gross employee benefits	4	2,113
Other costs	5	2,735
Other operating revenue	2	(449)
Net administration costs before interest		**4,399**
Programme Expenditure		
Gross employee benefits	4	342
Other costs	5	212,962
Other operating revenue	2	(3,524)
Net programme expenditure before interest		**209,780**

Other Comprehensive Net Expenditure	**2013-14 £000**
Impairments and reversals	-
Net gain/(loss) on revaluation of property, plant & equipment	-
Net gain/(loss) on revaluation of intangibles	-
Net gain/(loss) on revaluation of financial assets	-
Movements in other reserves	-
Net gain/(loss) on available for sale financial assets	-
Net gain/(loss) on assets held for sale	-
Net actuarial gain/(loss) on pension schemes	-
Share of (profit)/loss of associates and joint ventures	-
Reclassification Adjustments	
On disposal of available for sale financial assets	-
Total comprehensive net expenditure for the year	**214,179**

The notes on pages 64 to 96 form part of this statement

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment		-
Intangible assets		-
Investment property		-
Trade and other receivables		-
Other financial assets		-
Total non-current assets		**-**
Current assets:		
Inventories		-
Trade and other receivables	17	1,655
Other financial assets		-
Other current assets		-
Cash and cash equivalents	20	-
Total current assets		**1,655**
Non-current assets held for sale		**-**
Total current assets		**1,655**
Total assets		**1,655**
Current liabilities		
Trade and other payables	23	9,832
Other financial liabilities		-
Other liabilities		-
Borrowings	26	88
Provisions	30	343
Total current liabilities		**10,263**
Total Assets less Current Liabilities		**(8,608)**
Non-current liabilities		
Trade and other payables		-
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions		-
Total non-current liabilities		**-**
Total Assets Employed		**(8,608)**

Financed by Taxpayers' Equity		
General fund	SOCITE	(8,608)
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		**(8,608)**

The notes on pages 64 to 96 form part of this statement

The financial statements on pages 58 to 96 were approved by the Governing Body on 5 June 2014 and signed on its behalf by:

Clinical Accountable Officer
Dr Simon Douglass
5 June 2014

Statement of Changes In Taxpayers Equity for the year ended

31 March 2014

	Note	General fund	Reval-uation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		-	-	-	-
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition		-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**-**	**-**	**-**	**-**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year	**SOCNE**	**(214,179)**	**-**	**-**	**(214,179)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	-
Net gain/(loss) on revaluation of intangible assets		-	-	-	-
Net gain/(loss) on revaluation of financial assets		-	-	-	-
Total revaluations against revaluation reserve		**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets		-	-	-	-
Net gain (loss) on revaluation of assets held for sale		-	-	-	-
Impairments and reversals		-	-	-	-
Net actuarial gain (loss) on pensions		-	-	-	-
Movements in other reserves		-	-	-	-
Transfers between reserves		-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-	-	-
Transfers by absorption to (from) other bodies		-	-	-	-
Transfer between reserves in respect of assets transferred under absorption		-	-	-	-
Reserves eliminated on dissolution		-	-	-	-
Net Recognised CCG Expenditure for the Financial Year		**(214,179)**	**-**	**-**	**(214,179)**
Net funding	SCF	205,571	-	-	205,571
Balance at 31 March 2014		**(8,608)**	**-**	**-**	**(8,608)**

Net funding refers to the cash required to fund the activities of the CCG in the financial year. It does not directly relate to the maximum expenditure set for performance management (see Note 42). For 2013-14 the Net funding required is significantly less than the Recognised Expenditure due to 2013-14 being the first year of the CCG with a zero opening balance sheet and closing liabilities exceeding closing assets.

The notes on pages 64 to 96 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		(214,179)
Depreciation and amortisation		-
Impairments and reversals		-
Other gains (losses) on foreign exchange		-
Donated assets received credited to revenue but non-cash		-
Government granted assets received credited to revenue but non-cash		-
Interest paid		-
Release of PFI deferred credit		-
(Increase)/decrease in inventories		-
(Increase)/decrease in trade & other receivables		(1,655)
(Increase)/decrease in other current assets		-
Increase/(decrease) in trade & other payables		9,832
Increase/(decrease) in other current liabilities		-
Provisions utilised		-
Increase/(decrease) in provisions	30	343
Net Cash Inflow (Outflow) from Operating Activities		**(205,659)**
Cash Flows from Investing Activities		
Interest received		-
(Payments) for property, plant and equipment		-
(Payments) for intangible assets		-
(Payments) for investments with the Department of Health		-
(Payments) for other financial assets		-
(Payments) for financial assets (LIFT)		-
Proceeds from disposal of assets held for sale: property, plant and equipment		-
Proceeds from disposal of assets held for sale: intangible assets		-
Proceeds from disposal of investments with the Department of Health		-
Proceeds from disposal of other financial assets		-
Proceeds from disposal of financial assets (LIFT)		-
Loans made in respect of LIFT		-
Loans repaid in respect of LIFT		-
Rental revenue		-
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(205,659)**
Cash Flows from Financing Activities		
Net funding received		205,571
Other loans received		-
Other loans repaid		-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-
Capital grants and other capital receipts		-
Capital receipts surrendered		-
Net Cash Inflow (Outflow) from Financing Activities		**205,571**
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**(88)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**(88)**

The CCG cash position is reported in the financial statements as an overdraft due to payments scheduled to clear after the year end. As at 31 March 2014, the CCG had a net positive cash balance deposited in its Government Banking Service bank accounts of £3k.

The notes on pages 64 to 96 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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2013-14 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in Note 11 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in Note 30 to these financial statements.

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

Where the clinical commissioning group has entered into a pooled budget arrangement under Section 75 of the National Health Service Act 2006 the clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budget, identified in accordance with the pooled budget agreement.

If the clinical commissioning group is in a "jointly controlled operation", the clinical commissioning group recognises:

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

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

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

1.7 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.

1.7.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

- There have been no critical judgements made by the clinical commissioning group's management.

1.7.2 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 Provision for Continuing Health Care was based on assumptions detailed in Note 30
- the Provision for Other was based on solictor's advice

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

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

1.9.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

Where employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme, the scheme assets and liabilities attributable to those employees would be identified and recognised in the clinical commissioning group's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.10 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.11 Property, Plant & Equipment

1.11.1 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.

1.11.2 Valuation

All property, plant and equipment are 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. All assets are measured subsequently at fair value.

Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.

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. Fair values are determined as follows:

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

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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.

1.11.3 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.

1.12 Intangible Assets

1.12.1 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.

Intangible assets acquired separately are initially recognised at fair value. 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.

1.12.2 Measurement

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 fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 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 tangible 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.

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 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.

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 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.

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use.
The assets are measured initially at fair value in accordance with the principles of IAS17.
Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

On initial recognition of the asset, the difference between the fair value of the asset and the initial liability is recognised as deferred income, representing the future service potential to be received by the clinical commissioning group through the asset being made available to third party users.

The balance is subsequently released to operating income over the life of the concession on a straight-line basis.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 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.

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

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.

1.22 Clinical Negligence Costs

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.26 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.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.26.1 Financial Assets at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.26.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.26.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.26.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.27 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.27.1 Financial Guarantee Contract Liabilities

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.27.2 Financial Liabilities at Fair Value Through Profit and Loss

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

1.27.3 Other Financial Liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.28 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.

1.29 Foreign Currencies

The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.30 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.

1.31 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).

1.32 Subsidiaries

Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.33 Associates

Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.34 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.35 Joint Operations

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

1.36 Research & Development

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- FRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2 Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	120	120	-
Patient transport services	-	-	-
Prescription fees and charges	13	-	13
Dental fees and charges	-	-	-
Education, training and research	-	-	-
Page	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	-
Receipt of donations for capital acquisitions: NHS Charity	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-
Non-patient care services to other bodies	3,699	219	3,480
Income generation	-	-	-
Rental revenue from finance leases	-	-	-
Rental revenue from operating leases	-	-	-
Other revenue	141	110	31
Total other operating revenue	**3,973**	**449**	**3,524**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	3,973	449	3,524
From sale of goods	-	-	-
Total	**3,973**	**449**	**3,524**

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Total Other	Admin Total	Admin Permanent Employees	Admin Other	Programme Total	Programme Permanent Employees	Programme Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	2,081	1,728	353	1,783	1,448	335	298	**280**	**19**
Social security costs	151	151	-	136	136	-	15	**15**	**-**
Employer Contributions to NHS Pension scheme	223	223	-	194	194	-	29	**29**	**-**
Other pension costs	-	-	-	-	-	-	-	**-**	**-**
Other post-employment benefits	-	-	-	-	-	-	-	**-**	**-**
Other employment benefits	-	-	-	-	-	-	-	**-**	**-**
Termination benefits	-	-	-	-	-	-	-	**-**	**-**
Gross employee benefits expenditure	**2,455**	**2,102**	**353**	**2,113**	**1,778**	**335**	**342**	**324**	**19**
Less recoveries in respect of employee benefits (note 4.1.2)	**(120)**	**(120)**	**-**	**(120)**	**(120)**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**2,335**	**1,982**	**353**	**1,993**	**1,659**	**335**	**342**	**324**	**19**
Less: Employee costs capitalised	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	**2,335**	**1,982**	**353**	**1,993**	**1,659**	**335**	**342**	**324**	**19**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	(97)	(97)	-
Social security costs	(9)	(9)	-
Employer contributions to the NHS Pension Scheme	(14)	(14)	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**(120)**	**(120)**	**-**

4.2 Average number of people employed

	2013-14 Total	Permanently employed	Other
	Number	Number	Number
Administraton and Estates	29	25	4
Nursing, Midwifery and Health Visiting	2	2	-
Scientific, Therapeutic and Technical Staff	3	3	-
Total	**34**	**30**	**4**

None of the above are engaged on capital projects.

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	28
Total Staff Years	29
Average working Days Lost	1

The above figures were supplied by the Department of Health and are based on the figures for the 9 months from April to December 2013.

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

Where the CCG has agreed early retirements, the additional costs are met by the CCG and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

The CCG has no exit packages agreed in 2013/14

4.5 Pension costs

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

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

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme 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:

4.5.1 4.5.1 Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary 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 are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as “pension commutation”;

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	1,981	1,639	342
Executive governing body members	474	474	-
Total gross employee benefits	**2,455**	**2,113**	**342**
Other costs			
Services from other CCGs and NHS England	4,610	1,850	2,760
Services from foundation trusts	29,166	-	29,166
Services from other NHS trusts	91,950	-	91,950
Services from other NHS bodies	-	-	-
Purchase of healthcare from non-NHS bodies	61,866	-	61,866
Chair and lay membership body and governing body members	158	158	-
Supplies and services – clinical	1,303	-	1,303
Supplies and services – general	504	15	489
Consultancy services	140	140	-
Establishment	247	134	113
Transport	-	-	-
Premises	572	219	353
Impairments and reversals of receivables	-	-	-
Inventories written down	-	-	-
Depreciation	-	-	-
Amortisation	-	-	-
Impairments and reversals of property, plant and equipment	-	-	-
Impairments and reversals of intangible assets	-	-	-
Impairments and reversals of financial assets	-	-	-
• Assets carried at amortised cost	-	-	-
• Assets carried at cost	-	-	-
• Available for sale financial assets	-	-	-
Impairments and reversals of non-current assets held for sale	-	-	-
Impairments and reversals of investment properties	-	-	-
Audit fees	73	73	-
Other auditor's remuneration			
• Internal audit services	-	-	-
• Other services	-	-	-
General dental services and personal dental services	-	-	-
Prescribing costs	23,278	-	23,278

5. Operating expenses (continued)			
Pharmaceutical services	-	-	-
General ophthalmic services	7	-	7
GPMS/APMS and PCTMS	1,307	-	1,307
Other professional fees excl. audit	133	125	8
Grants to other public bodies	-	-	-
Clinical negligence	-	-	-
Research and development (excluding staff costs)	20	-	20
Education and training	56	21	35
Change in discount rate	-	-	-
Other expenditure	307	-	307
Total other costs	**215,697**	**2,735**	**212,962**
Total operating expenses	**218,152**	**4,848**	**213,304**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	2,107	37,904
Total Non-NHS Trade Invoices paid within target	2,025	37,624
Percentage of Non-NHS Trade invoices paid within target	**96.11%**	**99.26%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	1,698	118,177
Total NHS Trade Invoices Paid within target	1,648	117,734
Percentage of NHS Trade Invoices paid within target	**97.06%**	**99.63%**

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

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	2013-14
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income generation activities

The CCG does not undertake any income generation activities to report in 2013/14

8. Investment revenue

The CCG has no investment revenue to report in 2013/14

9. Other gains and losses

The CCG has no gains or losses to report in 2013/14

10. Finance costs

The CCG has no finance costs to report in 2013/14

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

The CCG has no gain/loss on transfer by absorption to report in 2013/14.

12. Operating Leases

An independent Sector Treatment Centre was opened in November 2009 at Emerson's Green, South Gloucestershire. There is a service agreement between Care UK Ltd, the service provider, and the Department of Health to provide an agreed range of treatments for the term of the contract. This activity is provided to and purchased by NHS South Gloucestershire CCG and CCGs adjacent to the area. An assessment of the contract against IFRIC 12, IFRIC 4 and IAS 17 has determined that an operating lease exists.

The price within the service contract uses the NHS tariff for secondary care. The service payment to Care UK Ltd at Emerson's Green in 2013/14 was £2,879k (2012/13 was £2,777k). In estimating the annual value of the operating lease the CCG has estimated the percentage of the tariff which relates to estate costs based on similar premises and determined this to be approximately 12%. (The tariff includes a contribution to the cost of the asset). The estimated value of the operating lease in 2013/14 was £344k (2012/13 was £333k). The estimate for 2014/15 is £349k.

12.1 As lessee

The CCG occupies and pays rent on St Martins Hospital. The CCG also pays rent in respect of vacant space at Keynsham Health Centre, Paulton Hospital, 4 Cambridge House and Riverside Health Centre. The properties are owned by NHS Property Services Limited. There are no contracts currently in place even though the nature of the transaction conveys the right for the CCG to use the property. Under paragraph 9 of IFRIC 4 these arrangements are a lease and as such accounted for in accordance with IAS 17. Payments in respect of this arrangement for 2013-14 are disclosed below. The CCG receives income from other organisations which occupy part of the St Martins property, although no contracts are in place relating to this arrangement. The lease income for 2013-14 is separately disclosed in these accounts. In the absence of formal contracts it is not possible to quantify the future minimum lease payments or lease income receivable.

12.1.1 Payments recognised as an Expense

	2013-14 Land £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense				
Minimum lease payments	-	550	-	550
Contingent rents	-	-	-	-
Sub-lease payments	-	-	-	-
Total	**-**	**550**	**-**	**550**

12.1.2 Future minimum lease payments

	2013-14 Land £000	Buildings £000	Other £000	Total £000
Payable:				
No later than one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Total	**-**	**-**	**-**	**-**

12.2 As lessor

The CCG has no operating leases as a lessor.

13 Property, plant and equipment

The CCG has no plant and equipment to report in 2013/14

14 Intangible non-current assets

The CCG has no intangible non-current assets to report in 2013/14

15 Investment property

The CCG has no investment property at 31 March 2014

16 Inventories

The CCG has no inventories at 31 March 2014

17 Trade and other receivables

	Current	Non-current
	2013-14	2013-14
	£000	£000
NHS receivables: Revenue	1,307	-
NHS receivables: Capital	-	-
NHS prepayments and accrued income	132	-
Non-NHS receivables: Revenue	50	-
Non-NHS receivables: Capital	-	-
Non-NHS prepayments and accrued income	-	-
Provision for the impairment of receivables	-	-
VAT	166	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables	-	-
Total	**1,655**	**-**
Total current and non current	**1,655**	

There are no prepaid pensions contributions

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

17.1 Receivables past their due date but not impaired	2013-14
	£000
By up to three months	89
By three to six months	23
By more than six months	-
Total	**112**

£64k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables
The CCG has not provided for impairment of receivables.

18 Other financial assets

The CCG has no other financial assets to report at 31 March 2014

19 Other current assets

The CCG has no other current assets to report at 31 March 2014

20 Cash and cash equivalents

	2013-14
	£000
Balance at 1 April 2013	**-**
Net change in year	(88)
Balance at 31 March 2014	**(88)**
Made up of:	
Cash with the Government Banking Service	(88)
Cash with Commercial banks	-
Cash in hand	-
Current investments	-
Cash and cash equivalents as in statement of financial position	**(88)**
Bank overdraft: Government Banking Service	(88)
Bank overdraft: Commercial banks	-
Total bank overdrafts	**(88)**
Balance at 31 March 2014	**-**

The CCG cash position is reported in the financial statements as an overdraft due to payments scheduled to clear after the year end. As at 31 March 2014, the CCG had a net positive cash balance deposited in its Government Banking Service bank accounts of £3k.

The CCG does not hold any patients monies

21 Non-current assets held for sale

The CCG has no non-current assets held for sale to report at 31 March 2014

22 Analysis of impairments and reversals

The CCG has no analysis of impairments and reversals to report at 31 March 2014

23 Trade and other payables

	Current	Non-current
	2013-14	2013-14
	£000	£000
Interest payable	-	-
NHS payables: revenue	1,971	-
NHS payables: capital	-	-
NHS accruals and deferred income	46	-
Non-NHS payables: revenue	1,028	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	6,611	-
Social security costs	25	-
VAT	-	-
Tax	32	-
Payments received on account	-	-
Other payables	119	-
Total	**9,832**	**-**
Total payables (current and non-current)	**9,832**	

There are no liabilities due in future years under arrangements to buy out the liability for early retirement over 5 years.

24 Other financial liabilities

The CCG has no other financial liabilities to report at 31 March 2014

25 Other liabilities

The CCG has no other liabilities to report at 31 March 2014

26 Borrowings

	Current	Non-current
	2013-14	2013-14
	£000	£000
Bank overdrafts:		
• Government banking service	88	-
• Commercial banks	-	-
Total overdrafts	**88**	**-**

The CCG cash position is reported in the financial statements as an overdraft due to payments scheduled to clear after the year end. As at 31 March 2014, the CCG had a net positive cash balance deposited in its Government Banking Service bank accounts of £3k.

27 Private finance initiative, LIFT and other service concession arrangements

The CCG has no private finance initiative, LIFT or other service concession arrangements to report at 31 March 2014

28 Finance lease obligations

The CCG has no finance lease obligations to report at 31 March 2014

29 Finance lease receivables

The CCG has no finance lease receivables to report at 31 March 2014

30 Provisions

	Current	Non-current
	2013-14	2013-14
	£000	£000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	-	-
Redundancy	-	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	222	-
Other	121	-
Total	**343**	**-**

Total current and non-current	Pensions Relating to Former Directors	Pensions Relating to Other Staff	Restructuring	Redundancy	Agenda for Change	Equal Pay	Legal Claims	Continuing Care	Other	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	-	-	-	-	-	222	121	343
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	-	-	-	-	222	121	343
Expected timing of cash flows:										
Within one year	-	-	-	-	-	-	-	222	121	343
Between one and five years	-	-	-	-	-	-	-	-	-	-
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**222**	**121**	**343**

Continuing Care
This provision relates to existing retrospective applications which may demonstrate eligibility for Continuing Healthcare (CHC) that have not yet been agreed by the CHC panel. This provision has been calculated by the number of new retrospective claims multiplied by the expected outcome, based on weekly rates.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the CCG. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £1,265k.

From 2014/15, all CCGs will contribute to a risk-sharing pool to be used by NHS England for legacy provision payments.

Other Provision - This provision relates to a potential industrial tribunal case and has been based upon solicitors' advice. NHS Bath and North East Somerset CCG - Annual Accounts 2013-14

31 Contingencies
The CCG has no contingencies to report at 31 March 2014

32 Commitments

32.1 Capital commitments
The CCG has no capital commitments to report at 31 March 2014

32.2 Other financial commitments
The CCG has no other financial commitments to report at 31 March 2014

33 Financial instruments

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

Because the CCG 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 CCG 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 CCG in undertaking its activities.

Treasury management operations are carried out by the Central Southern Commissioning Support Unit under contract with the CCG, within parameters defined formally within the CCG's standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

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

33.1.2 Interest rate risk
The CCG 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 CCG therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk
Because the majority of the CCG's revenue comes parliamentary funding, the CCG 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.

33.1.3 Liquidity risk
The CCG is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The CCG draws down cash to cover expenditure, from NHS England, as the need arises. The CCG is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14	2013-14	2013-14	2013-14
	£000	£000	£000	£000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	1,307	-	1,307
· Non-NHS	-	50	-	50
Cash at bank and in hand	-	-	-	-
Other financial assets	-	-	-	-
Total at 31 March 2014	**-**	**1,357**	**-**	**1,357**

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14	2013-14	2013-14
	£000	£000	£000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	2,017	2,017
· Non-NHS	-	7,639	7,639
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	88	88
Other financial liabilities	-	-	-
Total at 31 March 2014	**-**	**9,744**	**9,744**

33.4 Maturity of Financial liabilities

All financial liabilities mature within one year.

34 Operating segments

The CCG considers it has only one segment. The commissioning of healthcare services.

35 Pooled budgets

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

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

The audited memorandum accounts for the Pooled Budgets are:	Community Equipment	Children and Young People with Multiple and Complex Needs	Adult Learning Disability
	2013-14	2013-14	2013-14
	£000	£000	£000
Gross Funding			
Bath & North East Somerset Council	433	2,484	18,941
Bath & North East Somerset CCG	307	131	4,643
Income from client contributions	-	-	1,604
Interest on External Funding Balances	2	-	23
Total Funding	**742**	**2,615**	**25,211**
Expenditure	**742**	**2,462**	**25,211**
Net underspend repaid as detailed below	-	153	-
Bath & North East Somerset Council	-	145	-
Bath & North East Somerset CCG	-	8	-
	-	153	-

The Memorandum Accounts for Community Equipment was signed on the 23 May 2014 and Children and Young People with Multiple and Complex Needs and Adult Learning Disability were both were signed on 20 May 2014 by the Chief Financial Officer of Bath & North East Somerset Council.

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

36 NHS Lift investments

The CCG has no Lift investments to report at 31 March 2014

37 Intra-government and other balances

	Current Receivables	Non-current Receivables	Current Payables	Non-current Payables
	2013-14	2013-14	2013-14	2013-14
	£000	£000	£000	£000
Balances with:				
• Other Central Government bodies	-	-	136	-
• Local Authorities	77	-	721	-
Balances with NHS bodies:				
• NHS bodies outside the Departmental Group	181	-	563	-
• NHS Trusts and Foundation Trusts	1,258	-	1,454	-
Total of balances with NHS bodies:	**1,439**	**-**	**2,017**	**-**
• Public corporations and trading funds	-	-	-	-
• Bodies external to Government	139	-	6,958	-
Total balances at 31 March 2014	**1,655**	**-**	**9,832**	**-**

38 Related party transactions

Details of related party transactions with individuals are as follows:

		Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
		£000	£000	£000	£000
Hope House Surgery	Dr Simon Douglass	58	-	-	-
Newbridge Surgery	Dr Ruth Grabham	79	-	-	-
St Chad's Surgery	Dr Elizabeth Hersch	399	-	-	-
St James Surgery	Dr Ian Orpen	97	-	-	-
St Michaels Surgery	Dr James Hampton	92	-	-	-

The CCG has made payments for local enhanced service SLAs and dispensing drugs to GP practices of which members of the Governing Body are partners. These payments are to an organisation and not to individuals.

Dr Simon Douglass was only a partner for part of the year 2013-14

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 entities for which the Department is regarded as the parent Department.
NHS England
NHS Business Services Authority
NHS Litigation Authority
Royal United Hospital Bath NHS Trust
Avon and Wiltshire Mental Health Partnership NHST
University Hospital Bristol NHSFT
North Bristol NHST
South West Ambulance NHSFT
Royal National Hospital for Rheumatic Diseases NHSFT

In addition, the CCG 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 and North East Somerset Council.

39 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 CCG.

40 Losses and special payments

The CCG has no losses or special payments to report in 2013/14.

41 Third party assets

The CCG has no third party assets to report at 31 March 2014.

42 Financial performance targets

CCGs have a number of financial duties under the NHS Act 2006 (as amended).
This CCG's performance against those duties was as follows:

2013-14

	Maximum £000	Performance £000	Duty Achieved
Expenditure not to exceed income	221,217	218,152	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	-
Revenue resource use does not exceed the amount specified in Directions	217,244	214,179	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-
Revenue administration resource use does not exceed the amount specified in Directions	4,660	4,399	Yes

43 Impact of IFRS

IFRS has no material impact on the financial statements of the CCG.

44 Analysis of charitable reserves

The CCG does not hold any charitable reserves at 31 March 2014.

Appendix

9 Public Sector Equality Duty Report

Approved
This report was reviewed and approved by the CCG Board in March 2014.

Source notes
This report refers to and has sourced from a number of other documents and websites these are all listed, where possible with links, on the sources page at the back.

1. What is Public Sector Equality Duty?

Bath and North East Somerset Clinical Commissioning Group (BaNES CCG) is committed to eliminating all forms of discrimination and providing equality of opportunity for everyone. We recognise and value the diversity of our communities and believe that equality is pivotal to the commissioning of modern, high quality health services.

The Public Sector Equality Duty

During 2012 as part of our preparation and fulfilment of the conditions to become a statutory authority Bath and North East Somerset (BaNES) Clinical Commissioning Group (CCG) published an Equality and Diversity Strategy (E&D) and Action Plan to show how the CCG planned to comply with its equalities obligations.

With effect from 1 April 2013 all CCGs became subject to the legal obligations arising from the Equality Act 2010. Section 149 of the Equality Act 2010 places a Public Sector Equality Duty (PSED) on all statutory public authorities and those who act on their behalf. CCGs may not delegate these duties and are responsible for ensuring compliance by providers to whom the CCG commissions the delivery of services.

2. Meeting the Public Sector Equality Duty

The public sector equality duty is made up of a "general duty" which is the overarching requirement and the "specific duties" which are intended to help performance of the general duty.

The general duty has three aims and it applies to most public authorities, including the NHS Commissioning Board and CCGs (and bodies exercising public functions such as private healthcare providers), who must, in the exercise of their functions, have due regard to the need to:

Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited under the Act.
Advance equality of opportunity between persons who share a relevant protected characteristic1 and persons who do not share it.

Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Under the specific duties of the public sector equality duty, CCGs are required to publish in a manner that is accessible to the public:

1. Information to demonstrate its compliance with the public sector equality duty at least annually, starting by 31 January 2014. This information must include, in particular, information relating to people who share a protected characteristic who are: its employees – (public authorities with fewer than 150 employees are exempt) people affected by its policies and practices.

2. Equality objectives at least every four years starting by 13 October 2013. All such objectives must be specific and measurable.

3. Publishing Equality Data - Service Users

The main source of data about equality for people in the BaNES area is the Joint Strategic Needs Assessment (JSNA).

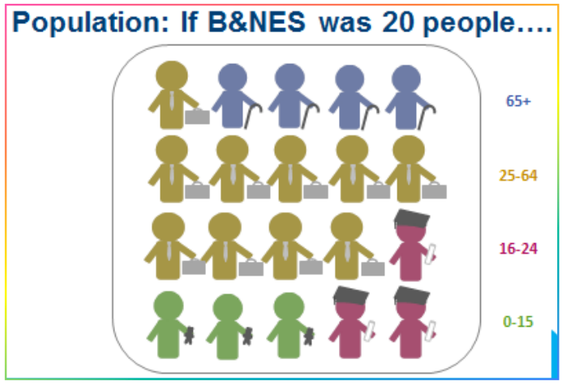
The JSNA is a collection of research about the local people, places and communities that BaNES Local Authority and BaNES CCG delivers services to. This is much wider than equality data. We use the JSNA to try to understand what needs to be done in collaboration with local knowledge and community feedback.

The Bath & North East Somerset Local Authority develop the JSNA for both organisations . In the last year the JSNA has moved from a static annual document to a live online "wiki" . This meets many of the Equality and Human Rights Commissions recommendations on publishing annual equality information as the data is online, easily available, more up to date, cross referenced and more comprehensive than previously issued annual reports.

The JSNA wiki is found on the local authority website here:

The easiest way to access the Equality data is to click on the browse by key contents button:
Look at the Section marked Equality Groups for gender, gender identity, sexuality, and ethnicity
Age and Disability are more integrated as they are key drivers of all local services including health.
Wider inequalities information also picks up on the protected characteristics.

* Wiki - a website or database developed collaboratively by a community of users, allowing any user to add and edit content.



National Health Inequalities for BME groups

Differences in the health of Black and other minority groups are most prominent in the following areas of health: mental health, cancer, heart disease and related illnesses such as stroke, Human Immunodeficiency Virus (HIV), Tuberculosis (TB) and diabetes. Additionally an increase in the number of older Black and other minority people in the UK is likely to lead to a greater need for provision of dementia services as well as the provision of culturally competent social care and palliative care.

Physical and Mobility Impairments Prevalence

Estimates from 2012, suggest 1 that there are 8451 people (7.6% of population) aged 18-64 who have a moderate physical disability and 2472 (2%) who have a severe physical disability. This is in-line with both regional and national percentages and increases with age. While numbers of persons classing as having a moderate or severe physical disability are estimated to fall in B&NES by 2030, the proportion as a percentage of 18-64 population is set to stay constant at 9.8%.

This is estimated to vary by age. Numbers of 18-24 year olds and 55-64 year olds with moderate or serious physical disabilities are estimated to increase by 3.4% and 6% respectively by 2030, while prevalence in those aged 45-54 is predicted to fall by almost 22% over the same period.

This trend is quite different to the estimated national change over the same period.

4. Publishing Equality Data - Employees

The CCG has around 45 employees. As this is below the threshold of 150, the CCG is not required to publish equality data about their staff. Practically, it is very difficult to publish data without showing cohorts with very small numbers of staff and compromising staff confidentiality.

A quarterly work force profile is made available to the Executive team and data taken from a report as at 31st October 2013 is shown below. Data on disability, ethnicity and religion / belief and sexual orientation is in the report but all report very low numbers for some protected characteristics and are not appropriate to publish.

Equalities data for staff is being recollected early in 2014 to increase accuracy.

Age Group	Number of Employees	% of Employees
20-39	11	26%
39-49	18	42%
50+	14	32%
Total	43	100%

Sex	Number of Employees	% of Employees
Male	12	28%
Female	31	72%
Total	34	100%

5. Equality in Governance

The BaNES CCG Constitution's principles of good governance include observing the Equality Act 2010.

In 2013 the CCG had delivered the key functions the CCG defined to meet the public sector equality duty by:

- Delegated responsibility for compliance with the public sector equality duty to the Accountable Officer - Dr Simon Douglass
- Designated an Equality and Human Rights operational lead - Tracey Cox, Chief Operating Officer
- Delegated responsibility for the review of arrangements relating to equality and human rights to the Quality Committee. This includes mandating Equality and Diversity training for all of its employees and providing an introductory session in using the JSNA for Commissioning Managers.
- Responsibility to seek assurance on the robustness of arrangements relating to equality and human rights stays with the CCG Board – in January the Board received an update regarding the arrangements in place and to approve the Equality Objectives 2014-17.
- Designated equality and diversity champions: Dr Simon Douglass, GP member of the Board and the lay member for PPI (currently being appointed).
- Prepared this first annual report on compliance with the public sector equality duty.
- Published the Joint Strategic Needs Assessment with the Local Authority in a new online dynamic format to make equality and human rights information available to everyone.

The key outstanding function for 2014 is to review and develop an Equality Diversity and Human Rights (EDHR) Strategy for approval by the CCG Board.

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6. Equality in Commissioning

Our aim is to commission modern, high quality health services that recognise and value the diversity of our communities and believe that meeting equality needs is pivotal to this aim. To turn this intention into a reality we carry out an Equality Impact Assessment as an integral part of commissioning projects.

An Equality Impact Assessment (or Equality Analysis) is a process of systematically analysing a new or existing policy or service to identify what impact or likely impact it will have on different groups within the community.

The primary concern is to identify any discriminatory or negative consequences for a particular group or sector of the community. Equality impact Assessments (EIAs) can be carried out in relation to service delivery as well as employment policies and strategies.

As we commission jointly with the B&NES Council Equality Impact Assessments are published on the CCG website or on the Council website.

Gypsy and Traveller Family Outreach Service

During the patient and public consultation on the proposed changes to urgent care the issue of access to health care provision for traveller communities was raised. This was re-enforced when completing the equality impact assessment for the proposed changes. In response a scoping exercise was conducted to identify what services were already commissioned and to consider how the CCG could provide support for this group and respond to their heath needs.

The result of this exercise was to commission a new proactive outreach Health Visiting service for families with children under 5 within the Gypsy and Traveller, Roma and Boater communities. The new service aims to ensure equality of access to preventative health services for the children and families of those who are nomadic, do not have a permanent address and who are not registered with local primary care services.

7. Equality in Quality Delivery

Equality in the access to and delivery of quality services is driven by the contract and monitoring of the contract between the commissioners, now the CCG, and the providers of health services.

The Contract and the supporting guidance highlight equality issues and refer to specific requirements, which will provide assurance that commissioners and providers are taking account of equality. They represent an instrument, which underpins the delivery of key policy requirements.

Examples of the equality requirements for providers within the 2014/15 contracts are:

- Comply with the 2010 Equality Act and where appropriate meet the Public Sector Equality Duty.
- Promote human rights and equality of opportunity and reduce health inequalities as per the 2010 Equality Act and Health and Social Care Act 2012.
- Monitor representation among employees of different protected characteristic groups.

- Undertake patient engagement actions to strengthen reporting and improve patient experience in areas of equality.
- Provide information when equality analysis is undertaken on services and changes to service provision as a result.
- Record patient protected characteristics especially ethnicity and publish patient profiling on selected protected characteristics.

8. Equality in Communication and Engagement

The CCG is working to improve consultation and engagement arrangements so that voices of all of the groups with protected characteristics and other vulnerable groups are taken into account in the CCG's planning processes.

In 2013 the CCG has held the "Call to Action" public stakeholder events across Bath and North East Somerset to discuss and invite input into future service planning. A specific session was held for children and their health needs.

Consultation with children and young people, parents and carers around the development of the Children and Young People's Plan (CYPP) 2014/17 priorities occurred from June to September 2013: This consultation influences the priority setting and commissioning intentions of both the Local Authority and the CCG. The CYPP aligns with the Health & Wellbeing Strategy.

The next stage is to put in place an on-going engagement tool: The Patient and Public Participation Group (PPPG) will be the mechanism by which the values, views and wishes of members of our local communities will help shape our commissioning intentions. We want to make sure that they have a direct line to decision-makers and can help develop policy. The PPPG will be in addition to the Patient Participation Groups associated with GP practices. This small group is unlikely to be able to represent all the protected characteristics groups and a specific engagement programme will be put in place to support input from wider equalities groups.

9. Equality Objectives

Equality Objectives for 2014-17 were published by the BaNES CCG in October 2013 as set out in the Public Service Equality Duty for CCGs. The Equality Diversity and Human Rights (EDHR) Strategy being developed in 2014 will include our 5 Equality Objectives.

1. Improve health and reduce the variations in access, experience and outcomes
   e.g. the development of the CCG's approach to self care will consider specific support and service needs for service users with protected characteristics.

2. Improve the collection and use of data and evidence for all protected groups
   e.g. data will be collected and analysed by all providers as part of their contractual agreement.

3. To communicate and engage well with protected groups
   e.g. engagement activities for service changes will reach groups with protected characteristics.

4. Develop our CCG Staff so that they are confident and competent in equality and diversity issues
   e.g. staff will be briefed on the local position on equality and diversity through JSNA updates and supported to use the information.

5. Develop the CCG's Leadership and Corporate commitment to Equality & Diversity
   e.g. there will be a review of the CCG's Equality and Diversity Strategy in light of guidance and developments.

10. Equality Delivery System 2

The BaNES CCG intends to implement the Equality Delivery Service 2 (EDS2) to ensure engagement with local partners and service users.

The Equality Delivery System (EDS) for the NHS was made available to the NHS in 2011. Following an evaluation of the implementation of the EDS in 2012, and subsequent consultation with a spread of NHS organisations, a refreshed EDS is now available. It is known as EDS2.

The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. At the heart of EDS2 are 4 key goals with 18 outcomes, against which NHS organisations assess and grade themselves. These outcomes relate to issues that matter to people who use, and work in, the NHS. Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions.

Without engagement with local stakeholders EDS2 will not work. Engagement refers to the process of getting local stakeholders involved in important decisions about the planning, developing, commissioning, management and delivery of health services in a sustained way. For staff, engagement also means helping to plan, develop and manage working environments, and activities that aim to improve working lives.

When using EDS2, the level of engagement will need to be deliverable. A focus on all services across all outcomes for all aspects of all protected characteristics can be overwhelming and unmanageable. It is much better to manage a comprehensive implementation of EDS2 over three to five years, through the use of informed selective choices at any one time.

11. Sources used in this report

Bath and North East Somerset (BaNES) CCG Equality & Diversity Strategy http://www.banesccg.nhs.uk/sites/default/files/CCG%20Equality%20%26%20Diversity%20Strategy.pdf

Clinical Commissioning Groups: compliance with the Legal Equality Duties http://www.england.nhs.uk/wp-content/uploads/2013/03/psed-guidance-ccg.pdf

The Equality and Human Rights Commissions assessment on Publishing Equality Information http://www.equalityhumanrights.com/uploaded_files/PSD/publishing_equality_information_final.pdf

The Joint Strategic Needs Assessment http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics

The population diagram http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/research-library/jsna-overview-and

The National Health Inequalities for BME groups http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/ethnicity

Physical and Mobility Impairments Prevalence http://www.bathnes.gov.uk/services/your-council-and-democracy/local-research-and-statistics/wiki/physical-and-mobility

The Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/contents

The BaNES CCG Constitution (full) http://www.bathandnortheastsomersetccg.nhs.uk/sites/default/files/BNES%20CCG%20Constitution%20V1%2010%20Final%20submitted%20-%20june%2013%20amendments.pdf

BaNES CCG Equality and Diversity Update to Board January 2014 http://www.banesccg.nhs.uk/sites/default/files/23-EqualityPaperCombined.pdf

BaNES CCG Equality Impact Assessments http://www.bathandnortheastsomersetccg.nhs.uk/equality-impact-assessments

Bath & North East Somerset Council Equality Impact Assessments http://www.bathnes.gov.uk/services/your-council-and-democracy/equality-and-diversity/equality-impact-assessments

NHS Equality Delivery System 2 http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

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