NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2015/16

26 May 2016

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1 INTRODUCTION

1.1 As Chair of Somerset Clinical Commissioning Group (CCG) I am delighted, on behalf of our member practices, to write this introduction to the Annual Report which covers our third year of operation as a CCG.

1.2 Overall 2015/16 has been a year of emerging change for the CCG and the local health and social care community. There have been a number of exciting projects designed to develop closer collaboration between organisations in Somerset, the most notable of which is the Somerset Together project which will lead to new outcome-based commissioning contracts being in place from April 2017. This has brought together leaders across health and social care to develop a vision and commitment for collaborative working to deliver integrated care focused on the needs of our patients.

1.3 This has been a considerable achievement on behalf of many people across health and social care at a time of continual high levels of demand, significant workforce and recruitment constraints, and an extremely challenging financial environment, and, high expectations from patients and the public, rightfully so.

1.4 There have been some significant achievements by the CCG and our partners and providers over the last year to celebrate. These include:

- maintaining high levels of patient satisfaction with local services as demonstrated through the Friends and Family Test and patient feedback
- the launch of a new and improved NHS 111 and the Out of Hours GP service in July 2015
- undertaking an extensive consultation and procurement to launch a new health campus in Shepton Mallet in 2017
- our local NHS Foundation Trusts performed well against the four hour Accident and Emergency access standard for decision making for patients on almost all occasions despite increasing demands and numbers of people requiring their services
- our local Vanguard programme to develop new models of care in South Somerset has made good progress in finding new ways to meet the complex needs of people with several long term conditions. There are test and learn pilots in Taunton and Mendip also taking forward ambitious plans for their populations
- we have started a significant programme of engagement around Somerset Together with patients and the public to understand the outcomes they would like to achieve and how services may change to meet these needs and we will be doing more in 2016/17
- achieving the financial surplus for 2015/16 of £6,484,000 in line with CCG plans.

1.5 In addition to all of these achievements, there are a range of important work programmes that have contributed towards achieving our five year strategy and which are outlined in more detail in this report:

- Enabling patients to take better care of themselves through personalised care planning
- Developing community services to better support people with long term conditions such as stroke, dementia, diabetes, asthma, cancer and COPD
- Maintaining good access to urgent and emergency care
- Improving important electives services like dermatology, ophthalmology and orthopaedics
- Ensuring that the quality of services remains high and that the views of patients and the public remain central when planning services in Somerset

1.6 Against the demographic and financial pressures it is now widely accepted that the way services are provided needs to change and the learning from these developments will be vital in informing how we commission services for our population in future. The 'Somerset Together' project is an exciting opportunity to do this. Somerset has often been at the forefront of developing new initiatives and this project will be another example of this and enable the significant change required to incentivise organisations to work together and focus intently on the outcomes that matter most to patients.

Our member practices

1.7 As well as the achievements made within the services we commission I also wish to acknowledge the significant challenges and achievements that continue to be made within our member practices.

1.8 Each day in Somerset, General Practice sees approximately 10,000 patients and receives approximately 3,400 requests of an urgent, same-day, nature. Across the nation, the pressures on General Practice have become widely known and these have arisen from high levels of demand, and workforce retention and recruitment gaps. This is no different in Somerset where General Practice is experiencing high demand and challenges in recruitment.

1.9 Despite these challenges, Somerset practices have continued to provide high quality care, enjoy high levels of patient satisfaction and GPs, practice nurses and other practice staff continue to be resourceful, highly committed and innovative as demonstrated in the national GP survey results.

1.10 Somerset is a relatively large CCG comprising of 75 member GP practices who have grouped together into nine commissioning localities. The localities are the main means through which the clinical views of member practices are gathered. They influence the strategic work of the

CCG's Governing Body and help to strike a balance between local and over-arching priorities.

1.11 Engaging with our member practices is extremely important, and we have and will continue to listen to members through a variety of means. Over the course of the last year we have met with practices individually, as localities and as part of countywide meetings. We have ensured the meetings of the Clinical Operations Group (COG) take place at different locations across the county and extended invites to member practices and Patient Participation Groups (PPGs) on each occasion.

1.12 Alongside opportunities to meet face to face we have conducted surveys, provided a range of communications and responded to feedback from practices that has been raised through COG delegates and the Healthcare Professional Feedback System.

1.13 Member Practices and staff within Somerset have continued to support the development of the CCG during 2015/16 and new and more collaborative relationships between our member practices and between clinical leaders across primary, community and secondary care have emerged. This is a critical development and an essential basis for the necessary move from the traditional service structures to new collaborative models.

1.14 In addition there has been significant awareness raised within the CCG member practices and within our partner organisations that a sustainable future will only be achieved if we work together. There has also been a growing acknowledgement that solutions need to come from within our health community.

Moving into next year

1.15 As we move into 2016 and 2017, I would like to wholeheartedly thank our member practices, our partners, patients, carers and the local community for their hard work and contribution to the NHS and their support for the CCG.

2 PERFORMANCE REPORT

Review of CCG Business for 2015/16

2.1 Somerset CCG covers a largely rural county of approximately 530,000 people across an area of 3,504km² including the districts of Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset (but not North Somerset or Bath and North East Somerset). This is a population that is 85% of the size of Bristol in an area nearly 24 times larger. West Somerset (containing much of Exmoor) is the 6th least densely populated district/unitary in the country.

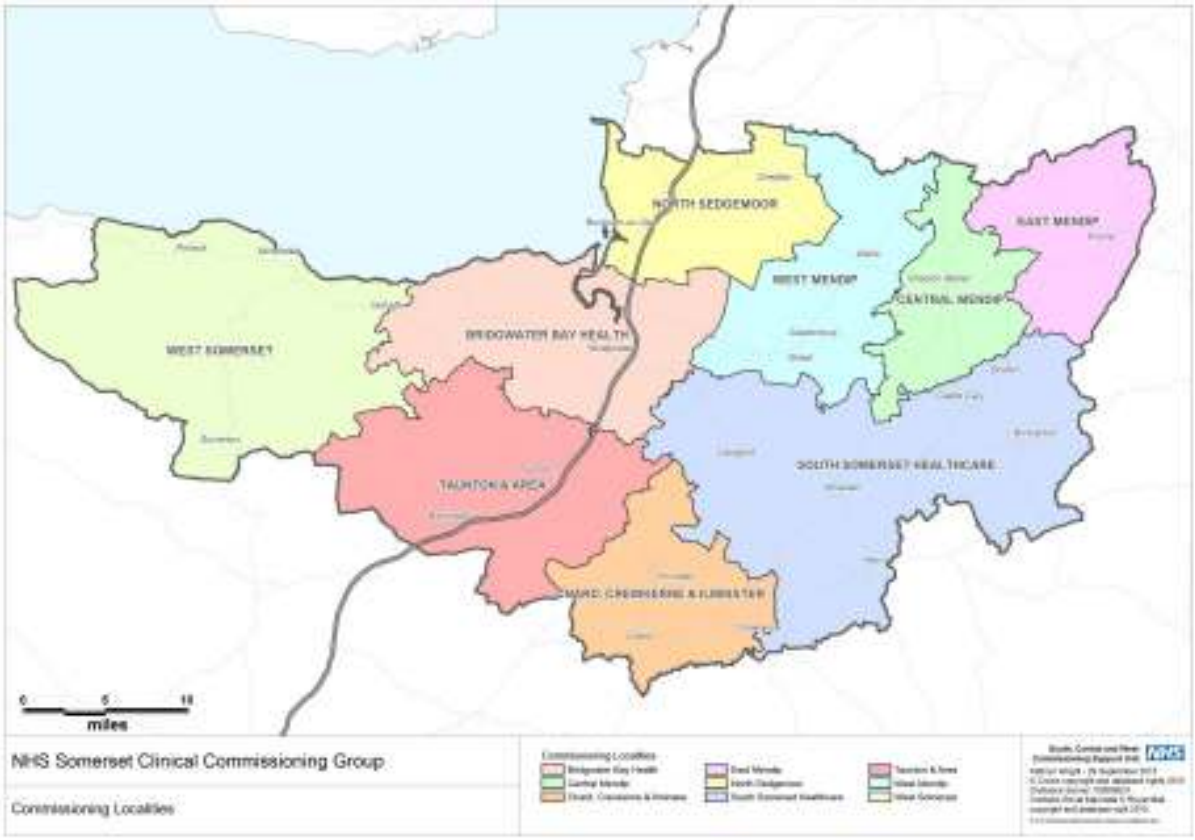
2.2 Somerset has on average a more elderly population than the South West region and England as a whole with more than one in five of the residents of the county being over 65. This ratio rises to nearly one in three being over 65 in West Somerset. A major factor is the trend for older people to move to the area later in life to take advantage of the more rural lifestyle

2. 3 Somerset has a particular dip in the population of 20 to 40 year olds compared to England and Wales as a whole. We believe this is due to younger people leaving the county for university and/or jobs.

2. 4 Overall life expectancy for Somerset residents is approximately two years higher than the national average for men and women. Over the past decade, death rates from all causes have decreased and those from coronary heart disease and cancer are lower than the national average.

2.5 However, Somerset does still experience health challenges, particularly in areas of high health and social need where people may experience lower levels of income and employment and lower life expectancy.

2.6 The geographical area covered by the NHS Somerset CCG is fully coterminous with the Local Authority (Somerset County Council) and District Councils (Mendip, Sedgemoor, South Somerset, Taunton Deane and West Somerset). Our 75 Member Practices are located within the County Council boundary, and can align themselves to one of nine localities as depicted:



2.7 The GP Commissioning Locality areas have been determined by member practices agreeing to informally group together to form localities. Member practices are not obliged to belong to a Locality.

2.8 Commissioning Localities, as a voluntary collaborative arrangement, contribute to the commissioning activities of the Somerset CCG and:

- act as local leadership groups for the NHS through which issues relating to NHS services can be raised
- develop relationships between GP members and other key stakeholders in health and care in order to address local problems and improve services for patients
- support the strategic decision-making of the Somerset CCG by collating local views of clinicians and patients
- spread consistent good practice across primary care, ensuring continuous improvement in quality
- listen to the views of local patients and the public and develop plans to address their concerns and suggestions
- educate patients and public about health issues

2.9 Tackling health inequalities and being focused on advancing equality has been a key strategic aim of Somerset CCG during 2015/16 and the CCG Two Year Commissioning Plan for 2014/16 set out the priorities for delivering the strategy in the following five core work programmes:

- Collaborative Working

- Community Services and Primary Care
- Urgent and Emergency Care
- Elective Care
- Improving Quality and the Patient Experience

2.10 In addition the CCG has been developing the Somerset Together project which will form the foundation for how services are commissioned for Somerset from April 2017.

2.11 The CCG has responsibilities under the NHS Act 2006 (amended) to discharge its duties in relation to:

- improvement in quality of services (section 14R)
- reducing inequalities (section 14T)
- promoting education and training (section 14Z)

2.12 Somerset CCG has its administrative headquarters, Wynford House, Lufton Way, Yeovil BA22 8HR.

2.13 The CCG shares its offices with teams from the South, Central and West Commissioning Support Unit, NHS England, Somerset Partnership NHS Foundation Trust, South West Ambulance Service NHS Foundation Trust and Yeovil Hospital NHS Foundation Trust.

2.14 The following sections of the Performance Report set out the work and the key ways in which the CCG has discharged these duties in the delivery of its strategic priorities.

COLLABORATIVE WORKING

2.15 During 2015/16, we have continued to make progress in improving collaborative working across all health providers and social care as part of the CCG's Collaborative Working Programme. The programme is seeking to help introduce changes in the way care is delivered which empowers people with long term conditions to acquire the knowledge, skills and confidence to self-manage their health and care. This is a high priority given the evidence base which shows that people with higher levels of knowledge, skills and confidence to self-manage have better clinical outcomes, better experiences of care and use health and social care services more effectively.

2.16 It is now widely considered that supporting people to increase their activation to manage their own health and care is key in enabling people to be in control of their own health and is a core focus for the NHS in order to improve people's quality of life and reduce demand on health and social care.

2.17 The Somerset Health and Social Care Community is one of a small number of areas in the country to start using the Patient Activation Measure (PAM). This is an internationally recognised and academically validated 13 statement survey which asks people questions about their knowledge skills and confidence to self-manage and provides an overall level and activation score.

2.18 So far in Somerset over 1,100 people have completed this and the response shows that around 40% of those completing it have low levels of activation. This means that they may have limited knowledge of their own health, may not see themselves as central to their health and care, and may not understand critical issues like their health care condition, their medication, or how to avoid exacerbations in their condition. The purpose of the PAM is to use the information with people, as part of a personalised care planning process to work in partnership with professionals to set realistic goals, for how they themselves will contribute to their health and wellbeing and to understand how local services can support them. For people who have undertaken second PAMs after a period of tailored support, the early indications are that their knowledge skills and confidence to self-manage has improved.

2.19 In the coming year, the CCG is seeking to significantly extend the use of the PAM and for there to be an increased focus on using the PAM results as part of a personalised care planning approach. Supporting people to improve their levels of activation is a key goal and a number of other work streams have been contributing to this described below.

House of care and personalised care planning

2.20 Central to the concept of activation is personalised care planning and during 2015/16 the CCG continued to make available the House of Care training. House of Care training is provided by nationally accredited trainers and is focused on enabling practitioners to have more effective collaborative care planning conversations with their patients and to improve consultation skills and person centred care planning. The training has been popular and so far over 200 local staff have attended. This has included 145 attendees from 45 practices (40 GPs, 59 practice nurse, 46 other practice staff) and 64 staff from other organisations including Somerset Partnership, Age UK Somerset, Village Agents, patient representatives. The training has continued to be developed in light of feedback received and it is the intention of the CCG that this continues to be made available.

2.21 To support some of the important aspects of personal care planning the CCG, in collaboration with local clinicians, practitioners and patient representatives has developed a care planning template called 'My Life Plan'. This incorporates some essential aspects of a person-centred approach which have often been missing in other, more medically orientated care planning templates. My Life Plan for examples seeks to describe a holistic view of an individual's life, their life situation as well as their concerns, their goals and their motivation to achieve these and the contribution that they themselves will make. These are coupled with important medical and other information and are designed for patients to own and take away. My Life Plan was thoroughly tested and has now been published for more widescale use across Somerset. The CCG intends the core elements of it to be embodied in NHS service contracts for NHS Foundation Trusts to use in future.

New service models, connecting with others and a menu of options

2.22 For people with long term, often complex conditions, services can feel fragmented and the CCG has been encouraging new models of care to be tested which bring GP practices and other organisations together in providing more joined up person-centred care. These include three Test and Learn pilot sites:

- one as part of South Somerset Symphony Vanguard Programme, known as the Complex Care Hub
- another in Taunton known as Taunton Symphony
- a third scheme due to commence in Mendip

2.23 These schemes are seeking to engage with patients using a person-centred care approach (adopting the House of Care principles), ensuring patients are at the centre of decision-making and that their plans are coordinated and joined up. The Test and Learn schemes are being evaluated by the South West Academic Health Science Network and Plymouth University using a wide range of measures including patients'

experience and use of services, their activation, and well-being as well as the experience of professionals.

2.24 In addition to these schemes, there are three other important pilot projects which are seeking to support people to engage more with the wide range of local community resources also available, and to engage with other people with similar conditions and life situations for mutual support. Having this other menu of options is important as some of the needs people seek to discuss with their GPs and health care professionals are more social in nature and they can get help and support in other ways. The three schemes are working closely with local GP practices and will be evaluated during 2016/17:

- Health Connections Mendip
- The Living Better Project in West Somerset
- The North Sedgemoor Village Agent Project

2.25 The progress made to date with all of these developments has only been possible through the hard work, commitment and good will of many staff within primary and community care and the third/voluntary sector. The CCG is extremely grateful to all who have contributed and made this progress possible. It is our intention to continue with this work in 2016/17 and for the learning from these to inform the ongoing development of person-centred care models and improved outcomes for people in Somerset.

Patient Story 1: Ellen's story: An example of self-care and collaborative working for people with long term conditions

Ellen is a young person who has lived with a rare long term condition ever since she was a baby. She became a SEND (Special Educational Needs and Disability) youth champion and, in this role, she shared her personal experiences with the CCG in order to help commissioners and managers gain a better understanding of the issues for young people when accessing health services. Her story raised the following issues:

- The importance of an accurate and early diagnosis;
- The need for clinicians to respect, listen to and take seriously the concerns of parents and carers of children with long term conditions;
- The importance of planning ahead;
- The specialist support that young people need, which is often not available until they transition to adult services;
- The value of being able to manage your own long term condition and set your own goals and ambitions.

COMMUNITY SERVICES

Making the Most of Community Services

2.26 During 2015, Somerset CCG worked with a range of stakeholders to build on the 'Making the Most of Community Services End Stage 2 Report' which set out a vision for the provision of community hospital based community services in Somerset. This was based on a service model with three components; step up care, step down care and health and wellbeing.

2.27 The End Stage 3 report, approved by the Governing Body in July 2015, outlines a Commissioning Framework for Community Services which supports the delivery of the CCG Five Year Strategy to deliver more care closer to where people live. There are nine recommendations, and these have been organised into a number of work streams that reflect each part of the model with a specific focus on the in-hospital community services, and strengthening delivery of community services.

2.28 In 2016, as part of the Somerset Together programme, Service Providers are being asked to design innovative new ways of working to specifically improve patient pathways and access to more joined up services. Their plan will prevent people unnecessarily staying too long in hospital or being admitted to care homes. The plan will use resources differently making best use of services available in the community, in line with the 'Making the Most of Community Services' recommendations.

Learning Disabilities

2.29 In October 2015 NHS England, working with the Local Government Association and the Association of Directors of Adult Social Services, published "Building the Right Support" which is a national plan to develop local community services and close inpatient facilities for children, young people and adults with learning disabilities and/or autism who display behaviour that challenges, including those with a mental health condition. A "Service Model" was published alongside this to provide advice and support for commissioners of health and social care services.

2.30 Somerset CCG has set up a local Transforming Care Partnership, working closely with Somerset County Council. The Partnership brings together the appropriate partners across health and social care systems including housing, Public Health, service providers, representatives of the Criminal Justice System and people with learning disabilities and autism (together with their families/carers) to co-produce a local plan to design services that are person centred and enable people with learning disabilities to achieve their aspirations. As part of the plan we have started to use care and treatment reviews to involve people and their families with independent specialist expertise to review their care needs, particularly where their behaviours can challenge and formulate a plan that achieves

their wishes and supports them in their local communities. This Plan will be implemented from 1 July 2016.

Stroke

2.31 Following a successful 2 year pilot in the Mendip area, a county wide Early Supported Discharge service has been commissioned. The service enables patients who have had a stroke to go home earlier from hospital and receive rehabilitation in their home environment. The model has been extended to pilot how patients with acquired brain injury can also be supported by the service and will be evaluated after 12 months.

Children and Young People's Mental Health

2.32 During 2015, NHS England required all CCGs to develop and submit a local transformation plan for children and young people's mental health and wellbeing. The Somerset plan was informed by the recommendations of the Future in Mind Report: promoting, protecting and improving our children and young people's mental health and wellbeing (DH, 2015), as well as local priorities.

2.33 Somerset CCG worked with partners to develop a transformation plan. The key aims of the plan are to:

- promote good mental health, build resilience and identify and address emerging mental health difficulties early on
- provide children, young people and families with straight-forward and prompt access to high quality treatment and support
- build skills, capacity and knowledge for all professionals who have a role in supporting children and young people
- improve care and support for the most vulnerable and disadvantaged children and young people by closing gaps in services and by tailoring and improving support, including attention to key transition points

2.34 The plan was fully approved by NHS England in November 2015, and this will enable transformation of services plus the development of an Eating Disorders Service for young people.

2.35 Additional investment has been made in Liaison Services during 2015/16 with new CAMHS liaison posts being recruited to, to provide additional support for young people with mental health problems who attend emergency departments at Musgrove Park Hospital and Yeovil District Hospital, and may be admitted to paediatric wards whilst waiting further treatment and care options. These posts will enable care and planning to be coordinated in a timely way to meet the needs of young people including specific focused work with frequent attenders. These posts respond to learning from serious incidents where it has been challenging to meet the needs of this group of young people on a paediatric ward.

Dementia

Diagnosis Rates

2.36 There has been a continued focus on increasing the percentage diagnosis rate of the estimated number of people aged over 65 living with dementia. The national ambition is for a minimum of 66% diagnosis rate, and at the end of March 2016 Somerset's diagnosis rate is 61.5%, an increase since March 2015. Earlier diagnosis of dementia helps people and their families to both actively keep well and to plan for their longer term care and support needs.

2.37 A number of initiatives have taken place over the year, including a Somerset Diagnosing Dementia Event, with a presentation from the National Clinical Lead for Dementia as well as individual practice visits from a local GP Registrar and Dementia Scholar.

2.38 Somerset will continue to strive for increased dementia diagnosis rates during 2016/17 and has a local ambition to achieve 69% by March 2017.

2.39 Somerset CCG and Somerset County Council will publish its refreshed Joint Dementia Strategy in 2016. The refreshed strategy will have an increased focus on de-stigmatising and normalising dementia; through developing community understanding and support.

Somerset Bone Health and Falls Pathways

2.40 Two new Somerset Care Pathways to promote bone health and prevent falls for older people have been developed and are already in use. These pathways were developed in association with Somerset stakeholders and are the result of a number of engagement events and workshops.

2.41 The new Bone Health Pathway covers the person's whole life span, including prevention and promotion of bone health, risk identification, and proactive review and treatment after someone (over 50) has had a fracture, as well as care at end of life.

2.42 Somerset CCG has commissioned all four acute trusts serving the Somerset population (in Taunton, Yeovil, Weston and Bath) to provide Fracture Liaison Services, which means an enhanced service is now available in Yeovil, Weston and Bath and a new service has started in Taunton. This service systematically identifies, treats and refers all people over 50 years within a local population who have suffered one or more fragility fractures to appropriate services, with the aim of reducing subsequent risk of fractures. A fragility fracture is a fracture from a fall from standing height or less due to osteoporosis.

2.43 The Falls Pathway provides guidance on when to complete a 'Falls Risk Assessment Tool in Somerset' (FRATiS), and supports next steps, including information and resources available from Somerset Choices

website and access to advice from Health and Social Care. The expectation is that through implementation of the pathways we will promote bone health in our population and reduce the number of people at risk of falling and the number of people who fall and fracture, which can result in a significant loss of mobility and independence for people.

Diabetes

2.44 In 2013 Somerset CCG invested in the podiatry service to improve access for people with diabetes who are at risk of developing complications that can mean their feet are at risk from damage that can be caused by ill-fitting shoes or poor foot care. This, together with an awareness tool has had a positive impact reducing the numbers of people with diabetes who have required major limb amputations in Somerset (Table 1). This has reduced significantly since the investment began to take effect. The Somerset Diabetes Foot Service will continue to work towards minimising amputation rates for people in the county.

Table 1: Amputations Per 1,000 Adults With Diabetes in Somerset				
2010/2011	**2011/2012**	**2012/2013**	**2013/2014**	**2014/2015**
5.0	**4.6**	**4.4**	**4.4**	**4.2**

Asthma

2.45 In 2015 the Respiratory Clinical Programme Group launched a database that enables localities and practices to benchmark variation in asthma management for practice populations. This will inform priorities for improvement.

2.46 The National Review of Asthma Deaths (NRAD) recommends that all deaths of people from asthma are reviewed. In Somerset a clinical group has been established to review and identify the key learning from critical care admissions as well as deaths from asthma. This information will be used to try and prevent acute asthma attacks and deaths in future. Key findings from reviews in Somerset to date have included the importance of people with asthma having an asthma management plan that is shared with other services / agencies involved in the person's care and referring people for specialist review in line with national guidance.

Early Diagnosis of Cancer

2.47 In 2015, NICE published major new guidelines on the early detection of cancer. Somerset clinicians from primary and secondary care met to collaboratively agree a county wide plan to enable more patients to be diagnosed earlier with cancer in order to improve outcomes This has resulted in teams from breast and upper gastrointestinal multi-disciplinary teams working together to design new referral pathways. This work will continue in 2016.

2.48 Two local practice nurses completed a Macmillan Cancer Support funded Masters module in cancer nursing. They now work as clinical leads in primary care. Together with a Cancer Research UK funded health professional engagement facilitator and the Macmillan GP lead, they visit practices across Somerset to advise on variation and other cancer related issues. Since October 2015 they have visited 22 practices and are working towards increasing the cancer nursing workforce expertise for patients in primary care.

Chronic Obstructive Pulmonary Disease (COPD)

Community Nebulisers

2.49 Millbrook Healthcare was commissioned to provide the Community Nebuliser Service for COPD patients with effect from October 2015. They are responsible for the supply and maintenance of nebuliser equipment and consumables. By commissioning this service we have enabled patients to self-manage their needs by giving them direct contact with the provider to obtain consumables, and earlier help when repairs are required. The provider is also ensuring servicing and PAT testing is arranged annually.

Post Exacerbation

2.50 A pilot service, 'My COPD – Take Control', supporting patients who have been discharged from hospital following an exacerbation of their COPD, started in January 2016 and is currently accepting Somerset patients discharged from Weston General Hospital and Musgrove Park Hospital.

2.51 The service is provided by Totally Health and the British Lung Foundation and aims to reduce 30 and 90 day COPD re-admissions for patients through a combination of clinical health coaching with support, information and education. The patients receive up to three months' support through telephone clinical health coaching, patient self-management education and follow-up support. In addition, all participants are introduced to other local services for ongoing support, including pulmonary rehabilitation. After the programme has been completed a discharge report is sent to their GP.

2.52 A full evaluation of the pilot will take place in early 2017 and the results will be used to determine future commissioning arrangements.

Spirometry Assessment

2.53 In 2015/16 the CCG agreed to utilise some COPD funding to support work in primary care, to improve the outcomes for patients with this condition. Somerset Primary Healthcare has been commissioned to run the COPD and Micro-Spirometry Project across Somerset over the next three years. The new project aims to improve the accuracy of diagnosis and increase

the numbers of people accurately diagnosed at the early stages of the disease to improve outcomes through earlier treatment.

Somerset Non Emergency Patient Transport

2.54 Somerset Non-Emergency Patient Transport Services (NEPTS) are available for those patients who have a medical need or who are on a low income and need support under the Healthcare Travel Costs Scheme. Patients are guided through the application process by trained advisors at the Patient Transport Advice Centre based in Bridgwater.

2.55 During 2015/16 the medical eligibility criteria has been reviewed and updated to ensure the services are available for patients with a genuine need so they can attend their medical appointment in a timely manner. There have been a total of 142,490 journeys in Somerset, surrounding counties and further afield. The Somerset NEPTS ambulance service is currently provided by NSL Care Services Limited. For patients able to travel by car, services are provided by Transporting Somerset and British Red Cross, both of whom rely on and fully utilise a group of dedicated volunteer drivers, whose efforts for the community in Somerset are appreciated by all.

2.56 Users of these services should expect to:

- be informed when they will be collected
- arrive on time for their appointment
- be collected promptly following their appointment/treatment or discharge
- experience travel times which are reasonable and aligned to journey distance
- receive considerate and reliable care when using the services
- have their and their escort's needs fully considered when the booking agent has confirmed eligibility
- be kept informed by the provider in the event of a delay

2.57 The CCG has been leading the process to re-procure the NEPTS ambulance service during 2015/16 and a new five year contract has been awarded to E-Zec Medical Transport Services Ltd to take effect from 1 October 2016. Jointly commissioned with all three Somerset Foundation Trusts the expected benefits include:

- increase in the number of operational bases – reducing journey times and improving timeliness
- live vehicle tracking – which will improve journey planning and provide a better experience for patients
- a new fleet of vehicles tailored to needs of patients

PRIMARY CARE

Co-Commissioning

2.58 One of the changes following on from the NHS Five Year Forward View published in October 2014 was the introduction of Co-Commissioning which aimed to support the development of integrated out-of-hospital services based around the needs of local people.

2.59 In April 2015 the CCG entered into Joint Commissioning arrangements with NHS England. As a consequence the Somerset Primary Care Joint Committee was constituted with the primary purpose of jointly commissioning primary medical services for the people of Somerset.

2.60 The Primary Care Joint Committee is chaired by David Bell, a Non-Executive Director on the CCG Governing Body. The joint committee meets on a quarterly basis and has a diverse stakeholder membership which includes NHS England, Somerset CCG, patient representatives, GPs (both local and external to Somerset), Somerset County Council, Local Medical Committee, Healthwatch and Lay members. The Joint Committee has the responsibility to:

- jointly commission primary medical services for the population of Somerset
- make primary care commissioning decisions
- oversee the development and implementation of the Primary Care strategy and work plan
- oversee implementation of the CCG statutory duty to improve the quality of primary care

2.61 Since the first meeting in June 2015, the Committee has made a number of important commissioning decisions and oversees a number of Primary Care work streams, which include:

- designing a local approach to the national Primary Medical Service contract review
- creating and implementing the commissioning strategy for Primary Care Medical Services in Somerset 2015/2020
- overseeing the progression and development of the Somerset Practice Quality Scheme (SPQS) to improve outcomes for people with long term conditions
- receiving updates and monitoring information on the position of Primary Care across the county
- monitoring and overseeing the progress of programmes being directed nationally eg. Primary Care Transformation Fund

2.62 The Primary Care Joint Committee will continue to meet in public on a quarterly basis to carry out its functions relating to the joint commissioning of primary care medical services. The implications of full delegation will also be considered during early 2016/17 to inform a decision about application in October 2016.

Somerset Practice Quality Scheme (SPQS)

2.63 In 2015/16 Somerset CCG supported 55 member practices to improve the quality of care for patients through SPQS, the local alternative to the national Quality and Outcomes Framework (QOF). In July 2015 the CCG received a comprehensive evaluation report from the Academic Health Science network and the highlights were:

- Practices are making significant progress towards more person-centred care
- there has been an improvement in morale and practitioner experience
- there is no evidence that the quality of care has deteriorated

2.64 During 2015/16 the SPQS scheme continued to fund practices to work closely with other NHS organisations and to provide better joined up care for patients who have complex medical needs. It also continued to promote person-centred consultations in which the patient's needs and priorities guide the consultation.

2.65 Under the joint commissioning arrangements, NHS England and Somerset CCG have agreed to extend the SPQS pilot for the 2016/17 contractual year. This means Somerset will continue to be one of the few locations across the country where an alternative to QOF is being offered. All member practices have been offered the opportunity to participate in SPQS for 2016/17, regardless of whether or not the practice has participated in SPQS in previous years.

2.66 SPQS will continue to assist with the movement towards consistent measures of quality across the health system. This approach is being incorporated into the SPQS specification for 2016/17 with a new requirement that involves practices engaging in the Institute of Health Improvement (IHI) quality improvement programme. Having a quality improvement approach across the health system will lead to both secondary care and primary care clinicians using consistent approaches to quality improvement through small tests of change using real time data to learn and improve.

2.67 A further evaluation of SPQS has also been commissioned from the South West Academic Health Science Network. The aim of the evaluation is to establish if patient safety and quality of care is maintained under SPQS and to systematically establish evidence to determine if patients are receiving good quality person centred and coordinated care. The final report will be available in the summer of 2016.

URGENT AND EMERGENCY CARE

2.68 Providers across Somerset are working together to develop integrated urgent and emergency care services, overseen by the Urgent Care Programme Board (UCPB) so that patients with urgent care needs get the right advice in the right place, first time. The aim is to provide highly responsive urgent care services local to where people live wherever possible. The UCPB's focus is to connect all urgent and emergency care services so that the overall system works cohesively together.

2.69 The Urgent and Emergency Care Services Clinical Assurance Committee is a subgroup of the UCPB and reviews patient experience, quality and patient safety across the urgent care system. Often patients have used several urgent care services so this enables learning for improvement to be identified across the handover between services.

2.70 A number of task and finish groups have been established under the UCPB to progress the improvement programmes and these are:

- the 7 day services group has reviewed progress against the ten clinical standards and identified the standards where improvements can be made

- the A&E group is looking at how improvements can be made. These improvements can then be shared within the UCPB so that system wide actions can be identified and put into place across the county

- the Emergency Ambulatory Care group has focused on producing and collating guidance for certain conditions that can be managed in emergency ambulatory care, thus reducing the need for admission to hospital for patients. This information will be shared with primary, community and secondary care

- the Somerset Escalation Framework has been revised and is now in place across Somerset. The framework is used by all organisations at times of increased demand on health services so that all partners work together to ensure services can respond to patient need

- a Clinical Communication Document has been developed for use across the health community and to assist with communication between clinicians promoting continuity of care for patients . The document will form an appendix to My Life Plan, the patient's own self care plan currently being developed by health and social care providers in Somerset

Out of Hours Services

2.71 The CCG has commissioned a new NHS 111 and Out of Hours service from Somerset Doctors Urgent Care (SDUC). The new service commenced on 1 July 2015. The CCG meets with SDUC on a monthly

basis to review quality and governance, and ensure there is ongoing learning and improvements made in the way the service is delivered to respond to patient needs.

Delayed Transfers of Care

2.72 There have been a number of challenges for patients whose discharge from hospital has been delayed due to waiting for a package of care at home or onward transfer for further care.

2.73 Delayed transfers of care are robustly monitored by the CCG and all provider organisations to ensure appropriate actions are taken to enable patients to be discharged from hospital in a timely way. Specific schemes to reduce delays have also been put in place for the winter period funded from the Better Care Fund. A strategic delayed discharge group has been convened to establish the key blockages and the actions required to address these.

Winter Planning

2.74 The CCG has coordinated planning across health and social care to ensure that services are able to respond to increased demands on services during the winter and bank holiday periods. Winter Planning consists of holding winter planning workshops to develop actions plans, that predict likely demand, address business continuity plans, and ensure there are communications for the public at times of escalation, and holding a debrief event to capture key learning on how well services have worked together.

Severn Network

2.75 Somerset is a member of the Severn Network which replicates the trauma network and consists of the following CCGs: Bristol, North Somerset, South Gloucester, Bath and North East Somerset, Gloucestershire, Swindon, North Wiltshire and Somerset.

ELECTIVE CARE

2.76 The Elective Care Clinical Programme Group has focussed on the following clinical pathways for improving patient care:

- Dermatology/Teledermatology
- Ophthalmology
- Demand and Activity Management

Dermatology

2.77 Dermatology services across Somerset are under pressure as a result of significant growth in referrals due to the national cancer campaign and reductions in workforce capacity in a specialty with national recruitment challenges.

2.78 Action has been taken to secure additional capacity within the acute trusts where possible; however, this has been very challenging given the continual recruitment difficulties and is insufficient to meet the increasing demands on the service. To support this work, the CCG has invested in the development of GPs with Special Interests (GPwSI) in dermatology service to provide more treatment and care for people with skin conditions in primary care. In addition a teledermatology pilot has been extended in the Mendip area and is progressing well enabling GPs to seek timely advice from specialists in the care of their patients.

2.79 Workshops have been held throughout 2015 for both primary and secondary care, to develop a vision for the Somerset Dermatology Service that will:

- be an integrated service encompassing all aspects of care for patients with skin problems to ensure that they are seen in the most appropriate setting
- have a strong focus on prevention and also support people to self-manage long term skin conditions
- promote early diagnosis of skin cancer and treatment for all conditions in a timely way

Ophthalmology

2.80 The Ophthalmology Task and Finish Group was established with representatives from local providers, Somerset CCG, Local Optical Committee (LOC) and the Local Eye Health Network, as a work stream under the Elective Care Clinical Programme Board.

2.81 The work programme for ophthalmology has focused on:

- Cataract pathway
    - cataract pathway has been reviewed and updated to develop a more effective pathway for patients to be seen again in secondary care after cataract surgery on one eye, so patients no longer need to start the pathway again for their second eye and impact on patient lifestyle is now captured
- Age related macular degeneration (AMD)
    - Yeovil District Hospital NHS Foundation Trust (YDH) has developed a virtual clinic at South Petherton Hospital for AMD and glaucoma patients through locating specialist diagnostic optical scanners in the hospital. Taunton and Somerset NHS Foundation Trust (T&S) has also established a community virtual clinic with a mobile scanner so that all consultations except injections can be provided for patients closer to home

- Ocular hypertension

    - The working group proposed that The Royal College of Optometrists 2009 age-related guidance around the monitoring of patients should be added to the Ocular Hypertension pathway

- Acute Eyecare Service (ACES)

    - The working group was clinically supportive of the requirement for patients to be seen within 24 hours in the ACES service to be extended to 48 hours resulting in providing better management of capacity and demand

Demand and Activity Management

2.82 Across Somerset, there are a number of gaps between demand and capacity for some clinical services, in Primary Care, Secondary Care and Community Care

2.83 The CCG has been examining all stages of the patient pathway, from Primary Care, the interface between primary and acute services, outpatients, admitted patient care to follow up care through other innovative pathways in primary and community services

2.84 To actively manage demand the CCG developed:

- GP Information packs to enable practices to review their referral rates.
- patient website information advising patients on the waiting times for all providers
- locally developed software application that generates an Appointment Request Letter tailored to the choices selected for that patient

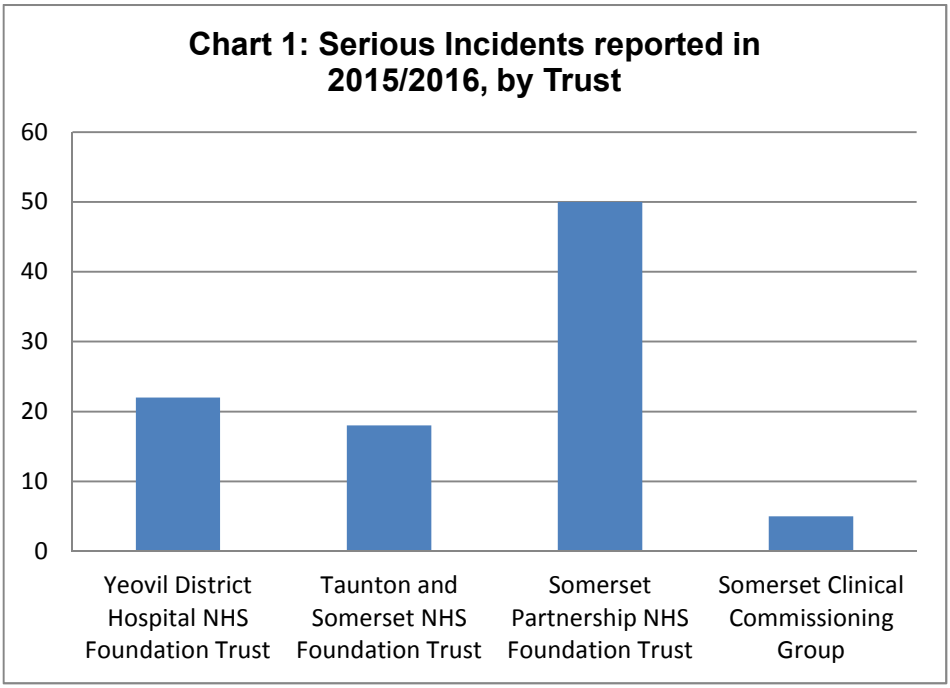
IMPROVING QUALITY AND THE PATIENT EXPERIENCE

Patient Safety Serious Incidents

2.85 Incidents which result in significant harm to patients receiving care funded by the NHS are required to be reported to NHS England. The CCG is responsible for ensuring a thorough investigation is carried out by the provider. The CCG independently reviews such investigations and ensures that lessons learned are embedded to improve the safety of care. Included in these reviews are incidents which are categorised as Never Events, these are events which are serious and largely preventable

patient safety incidents that should not occur if the available preventative measures have been implemented.

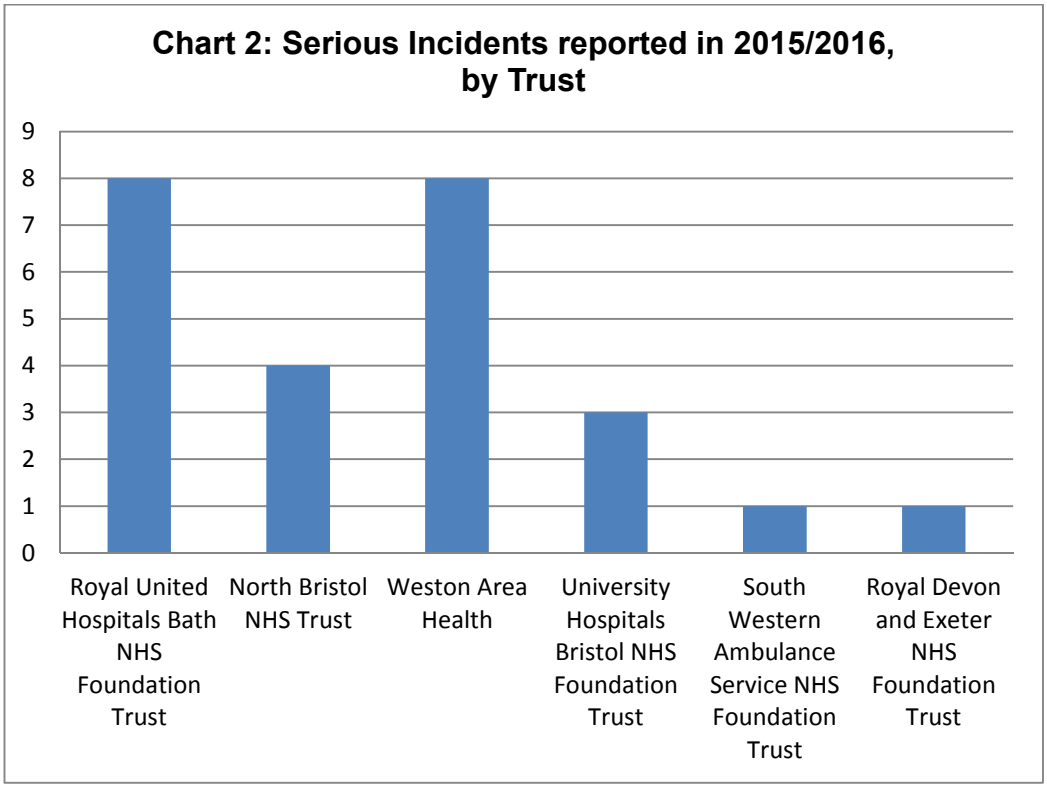
2.86 During the period 1 April 2015 to 31 March 2016, there were a total of 95 serious incidents reported by trusts for whom Somerset CCG is the main commissioner (Chart 1):



2.87 Included in these 95 serious incidents, were four 'never events' *('never events' are serious and largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented*). Details are as follows (Table 2):

Trust	Never Event Incident Type
Taunton and Somerset NHS Foundation Trust	Wrong site surgery x 2 (concerning wrong side anaesthetic block injections) Retained foreign object x 1 (concerning retained temporary screw tabs)
Yeovil District Hospital NHS Foundation Trust	Wrong site surgery x 1 (concerning wrong side chest drain insertion)

2.88 In addition to these 95 serious incidents, Somerset CCG were notified of an additional 25 serious incidents for trusts whereby Somerset CCG is not the lead commissioner, but which involved Somerset patients (Chart 2).



2.89 Of these 25 serious incidents, three were never events. Details are as follows (Table 3):

Trust	Never Event Incident Type
Weston Area Health	Wrong site surgery x 1 (concerning wrong site elbow release)
North Bristol NHS Trust	Wrong site surgery x 1 (concerning wrong vertebral disc)
Royal Devon and Exeter NHS Foundation Trust	Retained foreign object x 1 (concerning retained throat pack)

Lessons learnt from serious investigations

2.90 Lessons learned arising from serious incidents during the year includes:

Mental Health

- patients, families and carers should be involved in completion of holistic risk assessments for patients with mental health needs, to inform the overall assessment of risk and the risk formulation. This is a protective factor to reducing the risk of harm to the patient

Patients with Dementia

- risk assessments for patients who are at risk of wandering and mental capacity assessments should be completed in a timely

fashion and updated regularly to inform care planning for safe person centred care

- acute hospital staff should be aware of the potential risks associated with patients demonstrating a variable pattern of behaviours due to dementia and these should be addressed in the care plan

Frail Older People at risk of Falls

- admission of patients who are at risk of falls to hospital as a place of safety may not be the right option, as being in an unfamiliar environment can increase the risk of further falls for patients. There should be clear messages to patients and their families about the risk of falling for frail older people admitted to hospital

Communication and escalating concerns when patients deteriorate

- induction programmes for agency nurses need to include the use of early warning system recording and when to raise concerns and to act on changes in observations and patients reporting a change in condition

- handovers from the emergency department to inpatient wards should be undertaken by staff who are fully briefed on the patients' condition, reason for admission and plan of care to ensure safe onward care

- training to be provided to staff on emergency assessment unit to understand the 'normal' frequency of observations for trans ischaemic attack (TIA) patients i.e. mini stroke

Children and young people on paediatric wards with mental health problems

- the implementation of a number of changes in relation to young people with mental health concerns/self-harming when they are in the emergency department (ED) and when in-patients:

    - a clear management process for when patients present in ED for securing timely mental health assessment and contacts within Child and Adolescent Mental Health Services (CAMHS) and social care to assist with discharge / onward transfer from the department

    - formal agreements with the Community Mental health teams to ensure there are up to date shared care plans in place for frequent attenders with mental health problems at ED

- an annual training programme for staff on the management of self-harm and ligature risk assessments

- an Observation Policy to be developed for patients at risk of self-harm on paediatric wards

Safe Surgical Care

- the introduction of coloured wrist bands, corresponding to the number of vaginal swab packs in situ, to provide a visual reminder and failsafe

- surgical/theatre staff to be reminded that 'stop before you block' is crucial and should occur in the seconds before the block goes in and this should be a team approach to prevent other distractions

- the World Health Organisation (WHO) surgical safety checklist should be completed by the whole surgical team prior to and at the end of a surgical procedure and all staff should be supported to raise concerns if the process has not been followed correctly to provide a system of safe care for operations

2.91 Lessons learned arising from serious incidents during the year include:

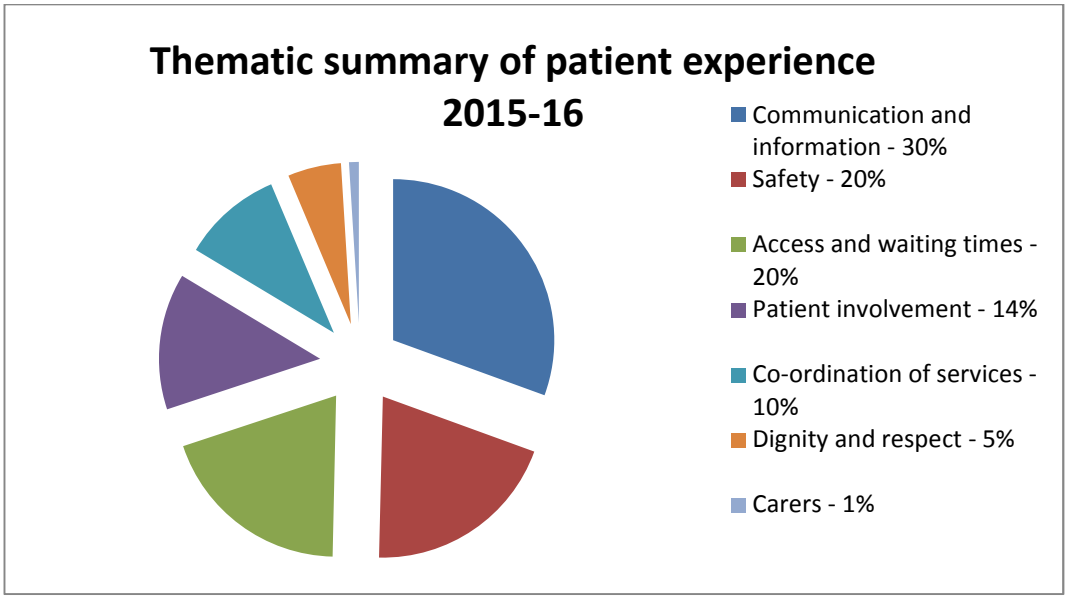
- admission of patients who are at risk of falls to hospital as a place of safety may not be the right option, as being in an unfamiliar environment can increase the risk of further falls for patients. There should be clear messages to patients and their families about the risk of falling for frail older people admitted to hospital

- families and carers should be involved in completion of risk assessments for patients with mental health needs to inform the overall assessment of risk and the risk formulation. Involvement strengthens risk assessments and can be protective to service users.

Complaints, Patients Concerns and Feedback

2.92 Somerset CCG values complaints and other forms of feedback, which are vital to continuously improve the quality of local health services and how services interact and are coordinated across the patient pathway. There are a range of mechanisms through which the CCG captures information about the quality of patients' experiences of healthcare and wider community intelligence. All feedback messages are captured, collated, analysed and categorised.

Chart 3: 2015-2016 Patient, public and professional feedback by category



2.93 During 2015/16 Somerset CCG received a total of 54 complaints. The main themes arising from complaints are:

- lack of information and therefore understanding for families in making continuing healthcare funding applications and lack of understanding about the length of time taken for decisions to be made
- co-ordination of care and services when people are reaching the end of life and access to timely pain relief out of hours, when people's pain rapidly escalates
- administrative errors and difficulties leading to delays in accessing services
- treatments which had not led to the improvement in health which had been expected, particularly in orthopaedics
- changes to medication due to new recommendations

2.94 The most frequent issues raised as concern enquiries relate to:

- help with arranging transport to hospital appointments
- waiting times for surgery
- difficulties booking appointments
- queries about medicines

- information about options available for treatment
- attitudes of staff and lack of sensitivity in breaking bad news
- lack of co-ordination and communication between services
- not being listened to / not being involved
- not kept informed by services
- difficulties in accessing the right information and support
- services not appropriate or tailored to needs
- delays in referrals to and discharges from services

2.95 Improvements that have been made to service delivery that has arisen wholly, or in part, from patient and family feedback include:

- a new webpage setting out waiting times for first outpatient appointments and improvements to letters sent for appointments in secondary care and providing more details on waiting times for patients

- further work to improve referral processes to reduce the number of referrals back to GPs thus reducing delays for patients in accessing services and diagnostic tests

- established joint working with Carers Voice Somerset and making a contribution to the Carer's Commitment action plan

- improved communication and clarity around the Continuing Health Care assessment processes with patients, families and carers

2.96 Somerset CCG, and our local health service providers, have continued to work with the Patients Association to continuously improve complaints handling and to ensure complainants in Somerset receive a responsive and compassionate complaints service. In November 2015 Somerset CCG hosted the third Somerset Complaints Peer Review. Participants commented on how very helpful the event had been in reviewing and evaluating their own organisation's complaints handling system. In recognition of the good practice in complaints handling having been developed in Somerset, Somerset CCG was invited to present evidence at the All Party Parliamentary Group (APPG) for Patient and Public Involvement in Health and Social Care in September 2015.

Patient Story 2: Brian's story: An example of how end of life care affects patients and their families and learning for how services can improve their approach

Having been bereaved last year, Brian very bravely and generously volunteered to share his experiences as the carer of his late wife. His intention is for the CCG and service providers to learn from his story and his hope is that end of life services can be improved as a result.

Brain's experiences have been recorded and shared in full with the CCG Governing Body members. His story raises a number of points, including:

- The need for greater co-ordination between hospital and community services in end of life care;
- The barriers faced by patients who choose to spend their last days at home, rather than in a hospital;
- Difficulties and delays in putting together palliative care packages at home and in the community;
- Frustrations and stresses experienced by terminally ill patients and their carers and families when care arrangements are delayed and delivery does not match what was promised;
- Communication problems between services and patients / carers, as well as between hospitals, community health and social care services;
- The need for clear communication, sensitivity, kindness when working with carers and family members of terminally ill patients.

2.97 Feedback from GP practices relating to the safety of health and social care provision in Somerset, via the Health Professional Feedback e-form has increased by 30% from the previous year, with all GP commissioning localities engaged with using the mechanism to inform the patient safety team of concerns, compliments and improvement ideas.

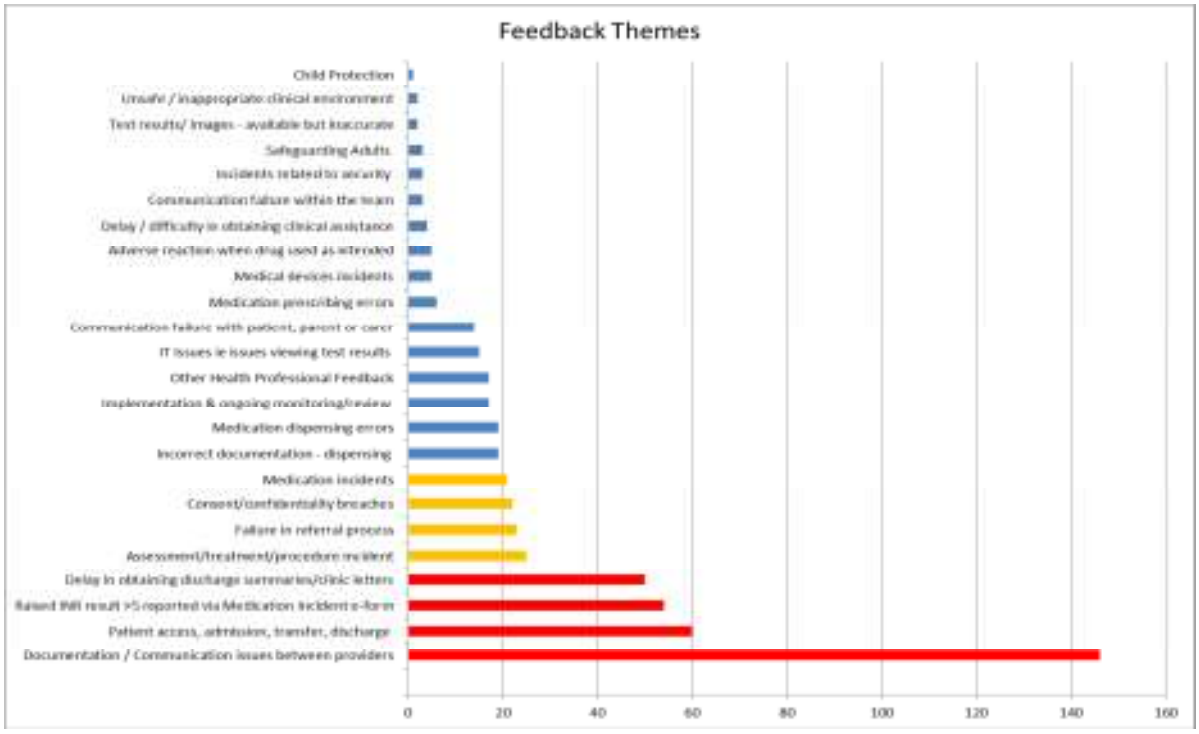
2.98 Every feedback message that the patient safety team receive is reviewed and escalated to the providers linked to the event. Emerging themes are monitored and high risk issues acted on promptly. The Complaints, PALS and CCG Feedback Managers work closely together and meet each week to identify any similar incidents that have the potential to escalate to actual harm in order to alert the provider and support them to implement improvements.

2.99 This year the Patient Safety Team has introduced a dedicated link that sits alongside Health Professional Feedback to provide a simple way of sharing Medication Incidents. The Patient Safety and Medicines Management team review all incidents reported to support learning and quality improvement in prescribing, dispensing and administration of medicines and learning is used within the Somerset Medication Safety

Network Improvement Programme to drive improvements across Somerset.

2.100 Chart 4 below shows the breakdown of the themes collected for both medication and health professional feedback, documentation and general communication continues to be the main theme of issues highlighted to the Somerset CCG. This category includes poor/missing documentation on discharge summaries and clinic letters, often presenting the GP with difficulties in caring for their patients after a hospital admission, which is often a critical time for patients and their families. The Somerset Clinical Documentation and Communication group monitor this theme, supporting a range of quality improvement initiatives with providers to make improvements in this area.

Chart 4: Feedback themes for April 2015 - March 2016



Sign up to Safety

2.101 In November 2014, NHS hospitals in Somerset joined 'Sign up to Safety', a national initiative to help make health services safer. During 2015, 47 GP practices joined the campaign in Somerset.

2.102 We are working in Somerset to get as many people and services involved as possible, working together to do what we can to reduce patient safety risks. By joining the campaign people / services make a pledge to:

- put safety first, by committing to reduce avoidable harm
- continually learn, acting on feedback from patients and staff and monitoring safety

- being honest, by being open about when things have gone wrong
- collaborating, working together so we can learn from mistakes and from each other
- being supportive, in understanding whey things have gone wrong and what can be done to put things right and give people the time to work on making improvements.

2.103 The main area of activity of Somerset CCG during the year has been to increase involvement in the campaign by patients and the public and getting local health services to make progress on our local priorities, which are:

- reducing the incidence of pressure ulcers
- reducing harm from falls
- earlier diagnosis and treatment of Sepsis
- improving clinical communication
- improving Medication Safety
- reducing Acute Kidney Injury
- safe use of restraint for challenging behaviour (in mental health services)

2.104 As an example, good progress was made in 2015 in converting letters which would have previously been sent in the post from hospitals to GPs to be sent as electronic messages. This has also meant patients are more reliably given a printed copy of their hospital discharge letter.

Patient Story 3: Mel's story: An example of how bereavement affects patients and learning for how services can improve their approach
Mel's story:

Following a stillbirth, Mel created Butterfly Boxes, which are memory boxes given automatically to bereaved parents on maternity wards. Each box contains a soft, fluffy blanket to wrap the baby in, two bracelets and a bottle of aromatherapy oil to create a smell memory.

Mel agreed to share her experience and her subsequent actions with the CCG in order to enable commissioners to consider how to improve the quality of commissioned services for parents who experience a still birth. Her story raises a number of issues, including:

- The value of the bereavement support received on the labour ward and the need for bereavement support in the community for parents who have lost a baby;
- The need to include and support the whole family, not only the mother;
- The importance of explaining what happened when a baby dies and of involving the family in the investigation;
- The value of involving bereaved parents in the subsequent training and development of midwives and other maternity staff.

Medicines Management

2.105 The Somerset CCG medicines management team works with GP practices to support clinically effective and safe use of medicines.

2.106 During 2015/16 this has included the roll-out of additional knowledge support software (Eclipse Live) to support prescribers in identifying clinical risk to patients from medicines based on analysis of clinical information about individual patients in the GP patient records. This has enabled GPs to make changes to medicines prescribed to reduce the risk of any adverse event to the patient.

2.107 As we get older our health needs change and so should our medicines. During 2015/16 we funded a new specialist pharmacist service. Working with GPs, 25% of care home patients had their medicines checked. The check revealed some patients were experiencing problems with their medicines, such as side effects resulting in changes and improvements to their medication plans. Residents and care home staff said they liked the new service and so it will be offered to more homes in 2016/17. The medicines management team has had a continued focus on identifying and treating unmet medication need balanced with a de-prescribing strategy to reduce medicines in the frail elderly such as care home residents where they were no longer clinically required.

2.108 During 2015/16 Somerset CCG continued to build upon its medicines optimisation strategy of developing 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'. This included a focus on medicines associated with the development of Acute Kidney Injury at times when a patient is suffering from illness related dehydration. We have continued to focus on our successful strategy to reduce the unnecessary prescribing of antibiotics in primary care in line with the Chief Medical Officer's national strategy to reduce the risk of bacterial infections resistant to the use of antibiotics.

Safeguarding Children and Young People

2.109 Somerset CCG has a duty to ensure that all statutory requirements for safeguarding as defined in the 'Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework' (2015) and 'Working Together to Safeguard Children (2015) are in place in all providers of NHS care. This requires all commissioned health services to have comprehensive policies and procedures in place to safeguard and protect the children and young people from abuse and neglect and to protect the most vulnerable whilst improving the outcomes and experiences for children, young people and families.

2.110 This is achieved by ensuring that all NHS providers:

- provide a positive experience of care

- ensure treatment and care for children, young people and their families is provided in a safe environment where they are protected from avoidable harm
- have arrangements in place to ensure staff are trained and competent to identify children and young people who may be at risk of or experiencing abuse and to take appropriate action to safeguard and protect them
- are raising awareness of child sexual exploitation and the warning signs that children and young people may be at risk

2.111 The CCG has continued to support improvements in Safeguarding in General Practices through provision of training, advice and participation in case reviews and learning events. The learning from recent serious case reviews has been embedded in training. A key message shared from these reviews with health professionals is 'non-cruisers do not bruise' and the evidence for this was demonstrated in the following serious case review.

Serious Case Review

2.112 In April 2015, a decision to initiate a serious case review (SCR) was made by the Somerset Safeguarding Children Board in accordance with the statutory guidance 'Working Together to Safeguard Children (2015). The incident involved an unexplained injury to a non-mobile infant, who was seen by the GP at a routine developmental assessment. On the observation of unexplained bruising the infant was referred to hospital where examination revealed further injuries. There were several risk factors identified in the family including domestic abuse, mental health needs and substance misuse by the parents and a previous incident of non-accidental injury involving the older child, who was discharged home with parents after a child protection assessment. The lessons learnt from this review and other incidents include:

- understanding the significance of family history
- information sharing across agencies working with the family
- over reliance on self-reporting by parents
- the importance of effective supervision for health and care practitioners and managerial oversight
- escalation process for raising concerns where there is a difference of professional opinion

Early Help

2.113 The CCG and NHS Trusts have participated in the Local Authority programme to implement the Early Help plan for Somerset, including participating in workshops and work streams. Early help is important for children and young people and their families to access services that can provide early intervention and help when problems are identified and prevent these adversely affecting the health and wellbeing of the child and young person. All NHS Trusts are supporting practitioners to undertake

Early Help Assessments and the CCG is monitoring the increase in use of early help assessments with all NHS Trusts through contract monitoring processes. The Early Help offer is also included in the safeguarding children training to primary care in preparation for the recently launched 'Effective Support for Children and Families in Somerset. All GP practices participate in the rolling triennial training offer and an annual safeguarding conference day is provided to GP child protection leads.

Safeguarding Adults

2.114 Somerset CCG is a member of the Somerset Safeguarding Adults Board (SAB). The Care Act (2014) requires the SAB to undertake Safeguarding Adults Reviews. These are reviews of treatment and care that are undertaken when an adult in the area dies or suffers severe harm and where agencies could have worked more effectively to protect the adult. In Somerset, two Safeguarding Adult reviews have been completed during 2015/16 to which Somerset CCG has contributed and a further three reviews are ongoing due to be completed in early 2016/17. The findings of the reviews included the need for a greater understanding for professionals of the Mental Capacity Act and how to implement this in assessing mental capacity, and improving the multiagency approach to risk management for adults at risk and management of domestic abuse.

2.115 In addition and in response to the requirements of The Care Act (2014), Somerset CCG and its providers have collaborated with partner agencies to develop multiagency safeguarding adults training and an information sharing protocol. This strengthens the level of co-operation that is required of all agencies in relation to working together to safeguard adults under the Act.

Care Home Support Team

2.116 The Care Home Support Team has been developed in the CCG to improve the outcomes and experiences for people who live in care homes. The team have worked this year with 51 out of the 60 nursing homes in Somerset to support people to remain in care homes rather than be admitted to hospital and to improve standards of clinical care. A learning and engagement network has been implemented this year by the Care Home Support nurse and supported by Taunton and Somerset Foundation Trust to provide joint training for care home and hospital staff , and improve the experience for people when they move form hospital to care home and vice versa.

2.117 Somerset CCG has invested in Quest for Care which is a web based tool that allows providers to self-assess their performance, identify areas for improvement and measure progress. This will support Care Homes to identify areas for quality improvement in the care provided to their residents.

Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards (DoLS)

2.118 Somerset CGG funded training in care homes in relation to the Mental Capacity Act. One care home, has since commissioned an independent trainer to speak at a relatives meeting to help families understand how to support their loved ones who lack capacity to make decisions about their care. Further case law has also increased the number of cases referred to the court of protection. Somerset CCG has this year been party to three cases that have been referred to the court of protection to make a decision about where their care needs should be accommodated.

Healthcare Acquired Infection

2.119 Somerset CCG has maintained a strong focus on reducing health care acquired infection. All NHS Trusts were set very challenging trajectories for reducing Clostridium Difficile cases acquired by patients in NHS hospitals as set out below (Table 4):

Health Care provider	Trajectory for 2015 - 16	YTD Reported Cases/ Avoidable Cases*
Somerset Clinical Commissioning Group	131	99 / 7
Somerset Partnership NHS Foundation Trust	5*	7 / 0
Taunton and Somerset NHS Foundation Trust	12	22 / 7
Yeovil District Hospital NHS Foundation Trust	8	15 / 3

* Final case numbers remain unconfirmed until peer review carried out in May 2016

2.120 Although all Trusts have exceeded these trajectories, post infection review has identified that few of these cases were preventable indicating that the antibiotic treatment for the patient's presenting condition was appropriate. The post infection investigation reports will be peer reviewed in May 2016 and will determine which cases, if any, could have been avoided.

2.121 Somerset CCG works with all providers, including Primary Care providers to ensure that shared root cause analysis are being undertaken to identify shared learning for improving patient care.

2.122 NHS England set healthcare providers the challenge of demonstrating a zero tolerance target for MRSA blood stream infections for patients through a combination of good hygienic practice, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance. MRSA blood stream infections are caused by methicillin resistant staphylococcus aureus.

2.123 Somerset CCG has collaborated closely with the organisations involved in providing patient care, to jointly identify and agree the possible causes of, or factors that contributed to, when patients have developed an MRSA bloodstream infection. In total Somerset has reported five MRSA bacteraemias during the year of which one was found to be unavoidable. Cases reported by local NHS Trusts as below:

- Yeovil District Hospital NHS Foundation Trust - 0 cases
- Taunton and Somerset NHS Foundation Trust – one case (assigned as a third party case which means that it was not possible to identify the cause of the infection)
- Somerset Partnership NHS Foundation Trust - 0 cases
- Somerset CCG - four cases (of the four cases, three were assigned as third party and upheld by PHE, therefore only one case found as unavoidable for CCG)

2.124 Achieving these low numbers of healthcare acquired infection across the health community is a significant achievement by all NHS providers in Somerset and an indicator of the robust infection control arrangements in place.

DEVELOPING SOMERSET TOGETHER

2.125 In response to the challenges of changing population demographics, financial austerity, and public expectation of the health services, Somerset CCG has made a commitment to use an alternative approach to commission services and has developed a programme of work, called 'Somerset Together' to introduce outcomes-based commissioning (OBC) for Person Centred Care Prevention.

2.126 Outcomes-based commissioning offers providers the incentives to collaborate and integrate the delivery of care around the individual and provides the means to improve outcomes that matter to the people using services.

2.127 The intention is that by April 2017 the County's health and care providers will be working in a fully joined up way. A longer term contract would replace annual service agreements. Financial incentives would reward the service providers for delivering the outcomes that really matter to the people of Somerset.

2.128 Over the past year, Somerset CCG and Somerset County Council have been working together with health, social care and voluntary sector providers to develop a clear vision which endorses a move to joined-up, integrated services for people who are able to make the right choices for their own long-term health and wellbeing.

2.129 The Governing Body approved the business case in July 2015 and a programme of work has been designed to support the development of a new contractual arrangement with providers. The programme of work includes:

- meaningful engagement with service users, the public and providers to co- design outcomes that will improve population health and wellbeing
- transform services with the alignment of incentives across health and social care economy
- maintain high quality services and value for money

2.130 Financial incentives in the contract will support achievement of outcomes for those patients with one or more long term conditions and the services included in the outcomes based contract include all services currently commissioned. An indicative financial envelope for the contract amounts to £653m, with a registered population of nearly 560,000 this results in an estimated capitation of c. £1,166 per person.

2.131 During the year we have reviewed the options as to whether a single contract for the whole of the county or several contracts for defined geographical boundaries in Somerset would enable providers to deliver services that are of high quality, affordable and sustainable. Based on the options appraisal most benefits can be gained by broadly splitting Somerset into two 'East' and 'West' lots.

2.132 To procure services for these two lots, Somerset CCG has taken legal advice to support a most capable provider commissioning approach to assess the extent to which local health and care providers have both the capacity and capability to work together to deliver improved outcomes for the population of Somerset.

2.133 Somerset CCG is now entering the next phase of the programme to work to:

- develop the financial framework
- assess local providers capability
- develop new contractual agreements
- continue to engage with the public and providers to support the transition to the outcomes based commissioning model.

STATUTORY RESPONSIBILITIES

Equality and Engagement

2.134 NHS Somerset CCG is committed to commissioning services in line with the needs and preference of patients, their families and carers, and ensuring that these are provided in a fair and equitable manner. We aim to achieve this by working with patients, the public and carers as well as service providers and other stakeholders, to plan, design and deliver services which support individual aspirations, meet their needs and deliver improvements in people's experience of NHS services in Somerset.

2.135 Somerset CCG is committed to meeting its statutory duties relating to patient, public and carer engagement, and equality, diversity and human rights, namely:

- S14Z2 NHS Act 2006 (as amended by Health and Social Care Act 2012)
- Equality Act 2010 including S149 Public Sector Equality Duty

Patient, Carer and Public Engagement

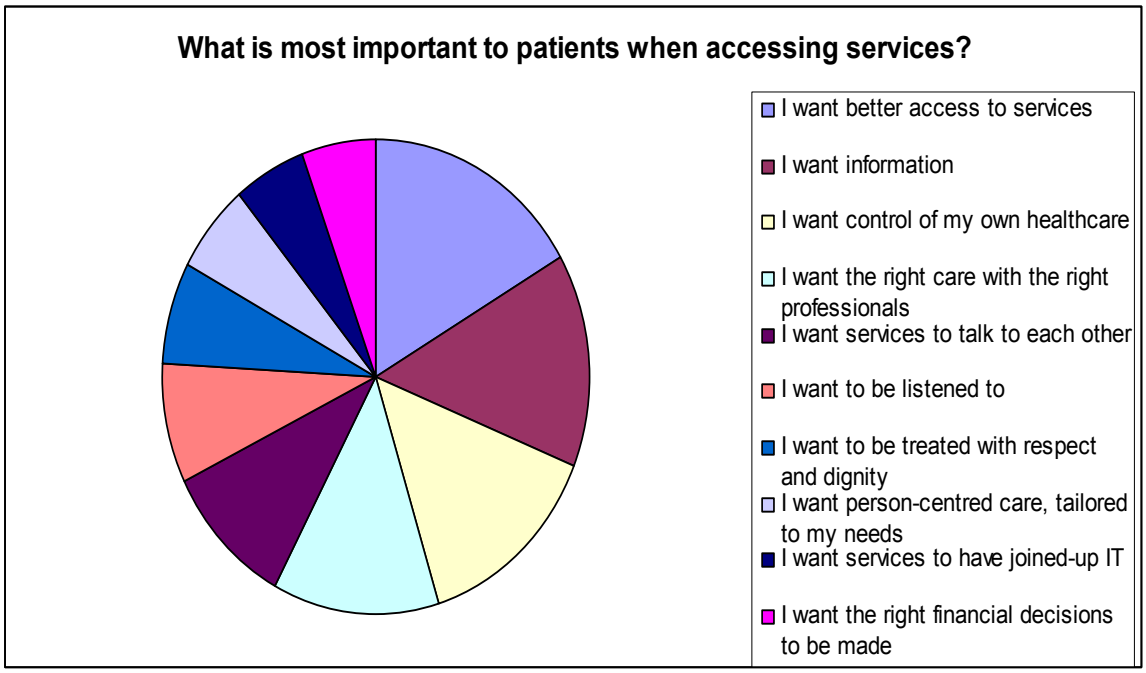
2.136 From April 2015 - March 2016 Health Forum meetings were held in each commissioning locality, bringing together a range of community stakeholders, including GP surgeries, voluntary organisations, Healthwatch volunteers and patient / carer representatives.

2.137 The Patient Participation Group (PPG) Chairs' Network also continues to be a valuable conduit through which the CCG shares and discusses commissioning plans, as well as providing a forum that can challenge and scrutinise the CCG's various commissioning programmes, and ensuring there is robust patient and public engagement.

2.138 The Somerset CCG Engagement Advisory Group (SEAG) has continued to be a key forum where the CCG engages with the voluntary and community sectors, Healthwatch volunteers, patient and carer groups and the County Council in its work.

2.139 The CCG engagement team ran six co-design workshops between February and March 2016 to engage members of the public in the design of outcomes for the Somerset Together programme. The purpose of the workshops was to generate evidence to directly support and inform the development of the outcomes framework that will be incentivized in the new contract. By identifying what is most important to patients and their families, we can develop a tool to measure the success of future services, commissioned to deliver those very outcomes. Ultimately, the feedback captured at the workshops will shape the development of the shared outcomes to be included in the single contract to which all providers would work.

2.140 The key themes and outcomes identified by the workshops are summarised in Chart 5 below:



Equality and Diversity Engagement

2.141 The CCG engagement team lead the Somerset EDS Group which is a useful forum in which the CCG, service providers and other stakeholders work together, exchange information and good practice, and support each other in the implementation of the Equality Delivery System, the Workforce Race Equality Standard and the Accessible Information Standard across Somerset. The 2015/16 Equality Delivery System Evidence and Grading Report will be compiled in April 2016 and published on our website.

2.142 Papers going to Clinical Operations Group (COG) or Governing Body are reviewed by the team to ensure there has been sufficient equality information included in the submission. Over the four quarters, 64 COG papers have been reviewed and recommendations for equality considerations have been made. This has also resulted in an increased number of Equality Impact Assessments being completed by the CCG for new policies and service redesign.

2.143 Key achievements in this work area in 2015/16 include:

- increasing the CCG's engagement of groups representing some of the protected characteristics, including young people, LGBT communities, faith communities, and other vulnerable groups, such as carers
- improving our corporate awareness of how to use equality impact assessments to inform and shape commissioning

2.144 **Highlights for the Patient and Carer Engagement Team**

- following a team nomination, Cheddar Patient Participation Group won an award at the CCG AGM. This was in recognition of the work they have done in their local community to raise the profile of the PPG, which included various events for PPG awareness week in June 2015
- the team conducted a survey of PPG chairs and CCG lay users in order to identify their skills, expertise and areas of interest. A further twenty PPG chairs have now volunteered to become lay users and get involved, both locally and across the county
- formalise the team is now regularly represented on the Healthwatch Executive and quarterly meetings have been set up between the CCG and Healthwatch managers to hear their patient feedback and link their work programme with CCG planned developments
- the team was successful in receiving a £12,000 grant from NHS England, on behalf of the EDS Group, to support us with implementing the Accessible Information Standard in our provider Trusts
- the team launched a survey to collect data about young people's experience of transition in diabetes services. We worked with Somerset Rural Youth Project to develop survey questions which would be accessible for young people and to distribute this via hospitals and schools. The results from this survey will be collated and used to inform future commissioning of diabetes services

Gender Profile of the CCG

2.145 The breakdown of the gender profile for the CCG as at the end of March 2016 is set out below (Table 5):

Category	% Male	% Female	Total Number
Governing Body Voting Members	67%	33%	12
Membership Body Clinical Operations Group Voting Members	60%	40%	15
Very Senior Managers	50%	50%	6
All substantive CCG Staff	20%	80%	126

Sustainability

2.146 The CCG adopted the Sustainable Development and Carbon Reduction Strategy and its associated plans that were put in place by Somerset Primary Care Trust and the CCG has continued to meet its obligations through the delivery of this plan. We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental

sustainability across policy development, business planning and in commissioning.

2.147 We have ensured the CCG complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

2.148 The CCG has continued to support its commitments as a socially responsible employer. This includes initiatives to:

- support the cycle to work scheme which also helps to improve the health and well-being of staff
- help the national NHS target of reducing carbon emissions through employee travel
- work with the waste management service provider to increase the amount of recycled materials
- reduce the use of printers and consumables and promote a paperless environment
- continue to integrate the principles of sustainability across the organisation

Emergency Planning

2.149 Somerset CCG works with the emergency services and local authorities to overcome potential disruption to civil life caused by major incidents, outbreaks of infection, severe weather or acts of terrorism. The responsibilities for emergency planning are set out in the Civil Contingencies Act 2004, Section 46 of the Health and Social Care Act 2012 and the NHS England Emergency Preparedness, Resilience and Response Framework 2015.

2.150 Somerset CCG is part of the Avon and Somerset Local Resilience Forum and the Local Health Resilience Partnership (LHRP) that covers Bristol, North Somerset, Somerset and South Gloucestershire. Planning is coordinated through the LHRP and the CCG has been an active member of both the executive and tactical steering groups. Somerset CCG has worked in partnership with NHS England during 2015/16 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in Somerset.

2.151 We confirm that Somerset CCG has emergency response plans in place, which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework 2015. The CCG regularly reviews and makes improvements to its incident response and business continuity plans and has a programme for regularly testing these plans, the results of which are reported to the Governance Committee and Governing Body. The CCG carried out a self-assessment assurance process with NHS England to assess the CCG plans and the CCG also met with its three key providers to review their plans.

Risk Management

2.152 The CCG's policy and approach to risk management is set out in detail in section 5 of the Governance Statement. The risk management and assessment process underpins the successful delivery of the CCG's strategy, achievement of its objectives and the management of its relationships with key partners.

2.153 The CCG is committed to maintaining a sound system of internal control based on risk management and assurance. By doing this, the organisation aims to ensure that they are able to maintain a safe environment for patients through the services it commissions, for staff and visitors, minimise financial loss to the organisation and demonstrate to the public that it is a safe and efficient organisation.

Health and Wellbeing Board

2.154 The CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2016 (Table 6):

Member	Organisation
Cllr Ann Bown (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr William Wallace	SCC
Cllr Anna Groskop	SCC
Cllr Ross Henley	SCC
Cllr Vivienne Stock-Williams	Taunton Deane Borough Council
Cllr Sylvia Seal	South Somerset District Council
Cllr Gill Slocombe	Sedgemoor District Council
Cllr Keith Turner	West Somerset District Council
Cllr Nigel Woollcombe-Adams	Mendip District Council
Dr Ed Ford	Somerset CCG
Dr Matthew Dolman	Somerset CCG
David Slack	Somerset CCG
Mark Cooke	NHS England
David Boyland	Healthwatch
Trudi Grant	Director of Public Health, SCC
Stephen Chandler	Director of Adult Social Services, SCC
Julian Wooster	Director of Children's Services, SCC

2.155 The Health and Wellbeing Board has a responsibility to consider the needs of Somerset and, with local partners and communities, develop a vision for health and wellbeing that we can all work towards. They look at people's health and social care needs together, as well as taking into account the bigger picture – for example transport, housing, jobs and leisure - so that services truly help people stay healthy and independent. The Board is responsible for the Health and Wellbeing Strategy for Somerset, which has been agreed by both Somerset County Council and the Somerset CCG, and also for key responsibilities such as the Joint

Strategic Needs Assessment, analysis of health inequalities and public health initiatives like the cessation of smoking during pregnancy.

2.156 During 2015/16, the CCG has taken an active role in the work of the Health and Wellbeing Board and supported the delivery of the 'Better Care Fund' plans which were required to be completed by every Local Authority and relevant CCG for submission to NHS England. The pooled fund that creates the Better Care Fund has been legally established though a 'Section 75' agreement signed by the CCG and Somerset County Council on 1 April 2015 and promotes closer integration of health and social care services, particularly in respect of older people.

2.157 In addition, the CCG's plans for the 'Somerset Together' project have been endorsed by the Health and Wellbeing Board and fully integrated with the Health and Wellbeing Board's own Strategy.

FINANCIAL AND PERFORMANCE ANALYSIS

Finances

2.158 NHS England has directed, under the National Health Service Act 2006 (as amended), that CCGs prepare financial statements in accordance with the 'Manual for Accounts 2015/16' issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2015/16 financial statements.

Operating and Financial Performance

Financial Duties

2.159 During 2015/16, Somerset CCG met all its financial duties (Table 7):

Table 7: 2015/16 Target Performance	Achieved
Expenditure not to exceed income	✓
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	✓
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	✓

2.160 Specific details of each of these duties are provided below:

Overview

2.161 For its third year in operation (1 April 2015 to 31 March 2016), Somerset CCG delivered all of its financial targets and delivered a planned underspend of £6,484,000 against its resource limit of £705,664,000 in line with the 'NHS Somerset Clinical Commissioning Group's Two Year Commissioning Plan 2015-17' and 'Five Year Strategy 2014-2019'.

Analysis of Revenue Performance (Table 8)

	2015/16 £'000
Revenue resource limit	705,664
Underspend against revenue resource limit	6,484
Percentage underspend against revenue resource limit	0.9%

2.162 Somerset CCG planned to deliver an under spend of £6,484,000 for 2015/16 representing 0.9% of the total funding allocation, against the portfolio of services it commissions, as agreed with NHS England.

2.163 The Financial Framework for 2015/16 details operational plans for the delivery of goals set out in 'NHS Somerset Clinical Commissioning Group's Two Year Commissioning Plan 2015-17' and 'Five Year Strategy 2014-2019'.

2.164 The Financial Framework for 2015/16 is underpinned by the vision of the Somerset CCG, namely:

- People in Somerset will be encouraged to stay healthy and well through a focus on:
    - building support for people in our local communities and neighbourhoods
    - supporting healthy lifestyle choices to be the easier choices
    - supporting people to self-care and be actively engaged in managing their condition

2.165 When people need to access care or support this will be through joined up health, social care and wellbeing services. The result will be a healthier population with access to high quality care that is affordable and sustainable.

2.166 During 2015/16, monthly financial reports were regularly presented to the Somerset CCG Governing Body highlighting the in-year performance and forecast year end outturn.

2.167 The Somerset CCG has established an Audit Committee whose role has centred on ensuring the adequacy and effectiveness of the organisation's overall internal control systems. The Audit Committee is appointed by the Governing Body and comprises of three Lay Members and a nominated GP. The Audit Committee is chaired by Lou Evans, who is also the vice chairman of the Governing Body, and held four meetings during the year and considered:

- governance, risk management and internal control
- internal audit
- external audit
- counter fraud
- other assurance functions

2.168 Through the work of the Audit Committee, the Governing Body has been assured that effective internal control arrangements are in place.

2.169 The following summary financial statements are an extract from the Somerset CCG's Annual Accounts for 2015/16, and describe how Somerset CCG used its resources to deliver health services to residents of Somerset during 2015/16. An explanation of the key financial terms can be found on pages 54-56.

2.170 The full copy of the set of audited accounts is available upon request, without charge, from:

Alison Henly
Chief Finance Officer and Director of Performance
Wynford House
Lufton Way
Yeovil
Somerset
BA22 8HR

E-mail: alison.henly@somersetccg.nhs.uk
Alternatively, the full document can be viewed on the Trust's website at:
www.somersetccg.nhs.uk/

SUMMARY FINANCIAL STATEMENTS

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2016

2.171 Operating costs and miscellaneous revenue are analysed between the administration costs (running costs) of the clinical commissioning group and all other expenditure (programme costs).

Table 9: 31 March 2016

	2015-16 £000	2014-15 £000
Total Income and Expenditure		
Employee benefits	6,152	5,312
Operating Expenses	696,649	667,961
Other operating revenue	(3,621)	(4,727)
Net operating expenditure before interest	**699,180**	**668,546**
Investment Revenue	0	0
Other (gains)/losses	0	0
Finance costs	0	0
Net operating expenditure for the financial year	**699,180**	**668,546**
Net (gain)/loss on transfers by absorption	0	0
Total Net Expenditure for the year	**699,180**	**668,546**
Of which:		
Administration Income and Expenditure		
Employee benefits	5,717	5,169
Operating Expenses	6,475	8,346
Other operating revenue	(361)	(346)
Net administration costs before interest	**11,831**	**13,169**
Programme Income and Expenditure		
Employee benefits	435	143
Operating Expenses	690,174	659,615
Other operating revenue	(3,260)	(4,381)
Net programme expenditure before interest	**687,349**	**655,377**

Other Comprehensive Net Expenditure	**2015-16 £000**	2014-15 £000
Impairments and reversals	0	0
Net gain/(loss) on revaluation of property, plant & equipment	0	0
Net gain/(loss) on revaluation of intangibles	0	0
Net gain/(loss) on revaluation of financial assets	0	0
Movements in other reserves	0	0
Net gain/(loss) on available for sale financial assets	0	0
Net gain/(loss) on assets held for sale	0	0
Net actuarial gain/(loss) on pension schemes	0	0
Share of (profit)/loss of associates and joint ventures	0	0
Reclassification Adjustments		
On disposal of available for sale financial assets	0	0
Total comprehensive net expenditure for the year	**699,180**	**668,546**

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

Going Concern

Introduction

2.173 The annual accounts of the CCG are prepared on the basis that the organisation is a ‘going concern’ and that there is no reason why it should not continue in operation on the same basis for the foreseeable future. Within the accounts, the CCG is required to make a clear disclosure that the individuals responsible for financial governance for the CCG have considered this position, and that given the facts at their disposal, the CCG is a 'going concern". Where there are material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the CCG, these should be disclosed as part of the disclosure notes supporting the annual accounts.

2.174 The Department of Health Group Manual for Accounts 2015/16 has the following recommendation as the standard accounting policy:

2.175 The CCG’s accounts have been prepared on a going concern basis.

2.176 The Government Financial Reporting Manual (FReM) (5.2.8) notes that in applying paragraphs 25 to 46 of International Accounting Standard (IAS) 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context:

- For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. However, a trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up.

- Sponsored entities whose statements of financial position show total net liabilities should prepare their financial statements on the going concern basis unless, after discussion with their sponsors, the going concern basis is deemed inappropriate.

- Where an entity ceases to exist, it should consider 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 in its final set of financial statements.

2.177 Should an NHS body have concerns about its “going concern” status (and this will only be the case if there is a prospect of services ceasing altogether) it should raise the issue with its sponsoring authority as soon as possible.

Criteria

2.178 IAS 1 requires management to make an assessment of the entity's ability to continue as a going concern when preparing the financial statements. The standard stipulates that in assessing if the going concern assumption is appropriate the management should take into account all available information about the future.

2.179 The period of review covered should be at least 12 months from the date of approval of the financial statements, but it should not be limited to the same. The assessment of the validity of the going concern assumption involves judgement about the outcome of events and conditions which are uncertain. The uncertainty increases significantly the further into the future a judgment is being made about the outcome of an event or condition. Therefore, usually the 12 month period from the balance sheet date is considered appropriate.

2.180 Financial statements should not be prepared on a going concern basis if management determines after the end of the reporting period either that it intends to liquidate the entity or to cease trading or that it has no realistic alternative to do so. In these circumstances the entity may, if appropriate, prepare its financial statements on a basis other than that of a going concern.

2.181 The Financial Reporting Council, in their publication 'Going Concern and Liquidity Risk: Guidance for Directors of UK Companies 2009,' has set out a number of areas Boards, or in CCGs, Governing Bodies, may wish to consider. Those relevant to CCGs in the NHS are as follows:

- Forecast and budgets;
- Timing of cash flows;
- Contingent liabilities;
- Products, services and markets;
- Financial and operational risk management;
- Financial adaptability;
- Documentation.

2.182 Where there are particular points to report or risks, these areas are reported to the Governance Committee and Governing Body, as part of the regular quarterly update, at the public meetings.

Financial Assumptions for 2015/16

Outturn

2.183 The financial outturn for 2015/6 is a surplus of £6.484m (0.9%), in line with the plan agreed with NHS England, This position has been reached through close contract management and through non-recurrent opportunities to use funding not fully committed during the financial year. Where there is no agreed year-end position with providers the CCG has used provider forecast positions in line with their accruals statements and best estimates where this is not available.

Financial Plan 2016/17

2.184 The CCG Governing Body approved the financial plan for 2016/17 at its meeting on 31st March 2016. The plan showed that whilst the CCG was meeting a number of the national business rules, the plan was based on a break-even financial position in 2016/17. Following discussions with NHS England, a revised plan was submitted showing the CCG delivering a surplus of £6.484million, representing the same level of surplus as 2015/16. This means that the CCG will not require to use the surplus delivered in 2015/16 to support the financial position. In order to deliver this financial plan, the CCG will need to deliver significant savings in year and a finance group has been established to support the development of the plan and focus on delivery. The CCG will still not be meeting the national business rule to deliver a 1% surplus, but will meet the remaining business rules published in the guidance for 2016/17 namely:• 0.5% Contingency (£3.6m)

- 1% Non-Recurrent spend (£6.9m)
- Reinvestment of balance of non-elective marginal rate
- Reinvestment of readmissions

2.185 The CCG has based its plan on published notified allocation of £693.3m including the Better Care Fund allocation, together with the further known adjustments that have not yet been formally notified, but are part of the latest national financial model as follows:

- Running cost allocation - £11.9m
- Return of 2015/16 surplus - £6.5m
- Quality premium payment - £1.5m

The overall Revenue Resource Limit is therefore £713.2m.

2.186 No account has been made for the impact of Primary Care Co-Commissioning or transfer of services from specialist commissioning during 2016/17.

2.187 The financial plans for 2016/17 have been based on a number of planning assumptions, which have in turn been taken from national planning guidance and local decisions.

2.188 A number of recurrent cost pressures and recurrent and non-recurrent investments are included in the financial plan and are aligned with service priorities. These have been drawn out in the detailed annual financial plan.

2.189 The impact of the above is that the CCG faces a financial challenge of £26.9m in 2016/17. Better Care Fund and QIPP schemes are well developed and are planned to save £18.6m, but this leaves a further £8.3m to be identified during the financial year.

2.190 In addition, the CCG has a number of risks which it needs to manage during the financial year and has therefore had to consider and planned for a series of mitigations and non-recurrent measures to bridge the remainder. These include the use of the contingency, changes to discretionary funding / investments and an assumption around further contract management.

Cash Flow

2.191 The cash position is reported to the Governing Body at each public meeting. In addition, detailed cash flow monitoring and forecasting is in place with NHS England on a monthly basis. The CCG met its cash requirements for 2015/6 and is planning to do so, on an on-going basis.

Contingent Liabilities

2.192 The contingent liabilities in 2015/16 relate to Continuing Healthcare and Her Majesty's Revenue and Customs.

2.193 A contingent liability is a possible obligation depending on whether some uncertain future event occurs or a present obligation but payment is not probable or the amount cannot be measured reliably

Services

2.194 The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is important evidence of going concern. The CCG is not aware of any plans that would fundamentally affect the services provided to an extent that the CCG would not continue to be a going concern.

Risks and Adaptability

2.195 The risks attached to the delivery of the financial programme are summarised below in line with the Financial Plan.

Planning Assumptions

2.196 The CCG has made a number of growth and activity assumptions that it considers reasonable, but there is a risk that activity exceeds this or issues arise in year that haven't been planned for.

2.197 Monthly detailed analysis and contract reconciliations done by contracting team followed by monthly Contract Management Board meetings with relevant Trusts will ensure any issues are identified and mitigation plans out in place.

Payment by Results

2.198 The guidance for 2016/17 was not published at the time of agreeing the financial plan and as such the impact of this was not taken into account in the financial plans.

QIPP

2.199 As highlighted about the financial plans are underpinned by the requirement to deliver £26.9m savings during 2016/17, of which £8.3m needs to be identified during the financial year. There is risk in the timelines for delivery of these schemes which could result in the full benefits not being realised during 2016/17.

In year volatility

2.200 Growth, pressure, NICE and price assumptions have been made in respect of GP prescribing in line with national and Medicines Management advice but the risk remains of overspend due to actual prescribing being in excess of this or unforeseen pressures arising in year.

2.201 A risk in respect of expenditure on continuing healthcare also remains. The programme spend for 2016/17 taken into account growth assumptions but a risk remains the actual levels of growth are higher than anticipated.

2.202 Although plans are clearly identified and developed the level of ambition is high in 2016/17 and further mitigations need to be developed to ensure the spend remains within the budgeted level.

Documentation

2.203 The Governing Body receive regular reports on the financial performance of the CCG which gives considerable assurance and documentary evidence of performance. Other documentation includes risk register reviews, Draft Financial Plan, Final Financial Plan, monthly QIPP reports and ad-hoc reports and information as required. The CCG also submits quarterly information to NHS England as part of the CCG assurance process.

2.204 To support the delivery of the savings required in 2016/17, the CCG has established a finance group which will meet on a bi-weekly basis to review the financial position and identify mitigating actions to ensure the CCG delivers its financial plans.

Recommendation

2.205 Having considered the position as set out above, it is recommended that management prepare the annual accounts for 2015/16 on a going concern basis.

Revenue Resource Limit

2.206 Somerset CCG has a statutory duty to maintain expenditure within the revenue resource limits, set by NHS England.

2.207 Revenue expenditure covers general day to day running costs and other areas of ongoing expenditure. The Somerset CCG met its statutory duty to operate within its revenue resource limit.

2.208 The Somerset CCG performance for 2015 /16 is as follows (Table 10):

	2015/16 £'000
Total net operating cost for the financial year	699,180
Final revenue resource limit for the year	705,664
Under/(over) spend against revenue resource limit	**6,484**

2.209 This table highlights that, in 2015/16 Somerset CCG underspent by £6,484,000 representing 0.9% of the Somerset CCG's resource limit. This funding will be returned to the Somerset CCG in 2016/17.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2016

2.210 The purpose of this statement is to identify gains and losses taken directly to reserves without going through the Statement of Comprehensive Net Expenditure.

Table 11: 31 March 2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(24,826)	0	0	**(24,826)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(24,826)**	**0**	**0**	**(24,826)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(699,180)			(699,180)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(699,180)**	**0**	**0**	**(699,180)**
Net funding	699,049	0	0	699,049
Balance at 31 March 2016	**(24,957)**	**0**	**0**	**(24,957)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(26,005)**	**0**	**0**	**(26,005)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(26,005)**	**0**	**0**	**(26,005)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating costs for the financial year	(668,546)			(668,546)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(668,546)**	**0**	**0**	**(668,546)**
Net funding	669,725	0	0	669,725
Balance at 31 March 2015	**(24,826)**	**0**	**0**	**(24,826)**

2.211 This statement records the movements in reserves for the year ended 31 March 2016.

Statement of Financial Position as at 31 March 2016

2.212 The statement of financial position records the assets and liabilities of the Somerset CCG as at the end of the financial year, and comprises two sections:

- the upper section shows the net assets/liabilities of the Somerset CCG
- the lower section identifies the source of finance used to fund the net assets/liabilities

Table 12: 31 March 2016

	2015-16	2014-15
	£000	£000
Non-current assets:		
Property, plant and equipment	394	181
Intangible assets	17	14
Investment property	0	0
Trade and other receivables	0	0
Other financial assets	0	0
Total non-current assets	411	195
Current assets:		
Inventories	2	2
Trade and other receivables	5,487	5,324
Other financial assets	0	0
Other current assets	0	0
Cash and cash equivalents	50	50
Total current assets	**5,539**	5,376
Non-current assets held for sale	0	0
Total current assets	**5,539**	5,376
Total assets	**5,950**	5,571
Current liabilities		
Trade and other payables	(29,997)	(29,875)
Other financial liabilities	0	0
Other liabilities	0	0
Borrowings	0	0
Provisions	(910)	(522)
Total current liabilities	**(30,907)**	(30,397)
Non-Current Assets plus/less Net Current Assets/Liabilities	**(24,957)**	(24,826)
Non-current liabilities		
Trade and other payables	0	0
Other financial liabilities	0	0
Other liabilities	0	0
Borrowings	0	0
Provisions	0	0
Total non-current liabilities	**0**	0

Assets less Liabilities	**(24,957)**	(24,826)
Financed by Taxpayers' Equity		
General fund	(24,957)	(24,826)
Revaluation reserve	0	0
Other reserves	0	0
Charitable Reserves	0	0
Total taxpayers' equity:	**(24,957)**	(24,826)

2.213 This statement records the assets and liabilities of Somerset CCG as at 31 March 2016.

Statement of Cash Flows for the Year Ended 31 March 2016

2.214 The Statement of Cash Flows provides information on the CCG's liquidity.

Table 13: 31 March 2016

	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year	(699,180)	(668,546)
Depreciation and amortisation	37	5
Impairments and reversals	0	0
Movement due to transfer by Modified Absorption	0	0
Other gains (losses) on foreign exchange	0	0
Donated assets received credited to revenue but non-cash	0	0
Government granted assets received credited to revenue but non-cash	0	0
Interest paid	0	0
Release of PFI deferred credit	0	0
Other Gains & Losses	0	0
Finance Costs	0	0
Unwinding of Discounts	0	0
(Increase)/decrease in inventories	0	0
(Increase)/decrease in trade & other receivables	(164)	(2,237)
(Increase)/decrease in other current assets	0	0
Increase/(decrease) in trade & other payables	(130)	1,184
Increase/(decrease) in other current liabilities	0	0
Provisions utilised	(320)	(270)
Increase/(decrease) in provisions	708	341
Net Cash Inflow (Outflow) from Operating Activities	**(699,049)**	(669,522)
Cash Flows from Investing Activities		
Interest received	0	0
(Payments) for property, plant and equipment	0	(185)
(Payments) for intangible assets	0	(15)
(Payments) for investments with the Department of Health	0	0
(Payments) for other financial assets	0	0
(Payments) for financial assets (LIFT)	0	0
Proceeds from disposal of assets held for sale: property, plant and equipment	0	0
Proceeds from disposal of assets held for sale: intangible assets	0	0
Proceeds from disposal of investments with the Department of Health	0	0

Proceeds from disposal of other financial assets	0	0
Proceeds from disposal of financial assets (LIFT)	0	0
Loans made in respect of LIFT	0	0
Loans repaid in respect of LIFT	0	0
Rental revenue	0	0
Net Cash Inflow (Outflow) from Investing Activities	**0**	(200)
Net Cash Inflow (Outflow) before Financing	**(699,049)**	(669,722)
Cash Flows from Financing Activities		
Net Funding Received	699,049	669,725
Other loans received	0	0
Other loans repaid	0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	0	0
Capital grants and other capital receipts	0	0
Capital receipts surrendered	0	0
Net Cash Inflow (Outflow) from Financing Activities	**699,049**	669,725
Net Increase (Decrease) in Cash & Cash Equivalents	**0**	3
Cash & Cash Equivalents at the Beginning of the Financial Year	**50**	47
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**50**	50

2.215 This statement records the movement in cash between 1 April 2015 and 31 March 2016. For 2015/16, the Somerset CCG's cash balance was maintained at £50,000.

Better Payment Practice Code

2.216 The Somerset CCG is required to pay its non-NHS and NHS trade payables in accordance with the Confederation of British Industry (CBI) Better Payment Practice Code. The target is to pay non-NHS and NHS trade payables within 30 days of receipt of goods or a valid invoice (whichever is the later) unless other payment terms have been agreed with the supplier.

2.217 The Somerset CCG's performance for the year ended 31 March 2016 is summarised below (Table 14):

Measure of compliance	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**15,480**	**112,703**	14,488	98,137
Total Non-NHS Trade Invoices paid within target	**15,386**	**111,739**	14,438	97,800
Percentage of Non-NHS Trade invoices paid within target	**99.39%**	**99.14%**	99.65%	99.66%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,289**	**490,873**	3,693	484,544
Total NHS Trade Invoices Paid within target	**3,230**	**485,076**	3,678	484,042
Percentage of NHS Trade Invoices paid within target	**98.21%**	**98.82%**	99.59%	99.90%

2.218 The Somerset CCG achieved the required 95% target to pay NHS and Non-NHS trade payables within 30 days (unless other terms had been agreed).

Cash Limit

2.219 The Somerset CCG is required not to exceed the cash limit set by NHS England, which sets the amount of cash drawings that the Somerset CCG can make in the financial year. The Somerset CCG drew cash totalling £699,049,119 (99.9%) against a cash limit of £699,765,511 meeting this requirement.

Running Costs

2.220 The CCG was funded £11.831 million, equating to £21.17 per head of weighted population, to support headquarters and administration costs. To support the effective running of the organisation, the CCG has reviewed those functions which it provides in house and those which are provided by South, Central and West Commissioning Support Unit. The value of services commissioned via the South, Central and West Commissioning Support Unit is £4,716,000 which covers Commissioning Delivery Support, Organisational Support, Referral and Booking Management Service and GP IT Services. Expenditure recorded against running costs for 2015/16 totalled £11.831 million.

Total Staff Costs

2.221 The Somerset CCG's total staff costs for the year ended 31 March 2016 are summarised in the following table 15.

Table 15: Employee benefits	2015-16 Permanent Employees	Admin Other	Total	Permanent Employees	Programme Other	Total	Permanent Employees	Total Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	4,558	175	**4,733**	232	152	**384**	4,790	327	**5,117**
Social security costs	389	6	**395**	21	-	**21**	410	6	**416**
Employer Contributions to NHS Pension scheme	546	8	**554**	30	-	**30**	576	8	**584**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	35	-	**35**	-	-	**-**	35	-	**35**
Gross employee benefits expenditure	5,528	189	**5,717**	283	152	**435**	5,811	341	**6,152**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	5,528	189	**5,717**	283	152	**435**	5,811	341	**6,152**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	5,528	189	**5,717**	283	152	**435**	5,811	341	**6,152**

Average Number of Persons Employed

2.222 The average number of Clinical Commissioning Group staff employed by staff grouping are as follows (Table 16):

4.2 Average number of people employed (Table 16)			2015/16	2014/15
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	3	0	3	4
Administration and estates	86	4	90	77
Nursing, midwifery and health visiting staff	6	0	6	2
Scientific, therapeutic and technical staff	7	0	7	7
Total	**101**	**4**	**105**	90
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

2.223 The majority of employees are members of the NHS defined benefit pension scheme. Details of the scheme and its accounting treatment may be found within the accounting policies disclosed in the full audited annual accounts.

Staff Sickness Absence

Staff sickness absence and ill health retirements (Table 17)	2015-16 Number	2014-15 Number
Total Days Lost	**420**	531
Total Staff Years	**93**	85
Average working Days Lost	**4.5**	6.2

2.224 2015-16 staff sickness values is based on a 12 month period covering the calendar year of 2015. 2014-15 staff sickness values are based on a 12 month period covering the calendar year of 2014.

2.225 The above table is based on figures provided by the Department of Health. The CCG has a clear and robust Management of Sickness Absence Policy.

Accounting Policies

2.226 Full details of the accounting policies used to prepare the accounts and summary financial statements can be found within Note 1 of the Somerset CCG's audited accounts.

Governing Body and Clinical Operations Group Members

2.227 Full details of the remuneration paid to Governing Body and Clinical Operations Group members and senior employees, which are included within the above management costs, are provided below, together with their pension entitlements and declarations of interest.

External Audit

2.228 The Grant Thornton UK LLP is the appointed external auditor for the Somerset CCG. The total fee paid to Grant Thornton UK LLP in 2015/16 was £85,500 including VAT to cover the cost of the statutory audit and associated services.

Governance Statement

2.229 The Managing Director, as Accountable Officer, publishes an Annual Governance Statement, confirming the systems for managing risk within the Somerset CCG. This statement is supported by the Head of Internal Audit who provides an opinion on the overall arrangement for gaining assurance through the Assurance Framework and on the effectiveness of the controls in place to mitigate risks.

2.230 A copy of the full Governance Statement is included in section 3.6 of this Annual Report and is also available on request or can be viewed on the CCG's website at:

www.somersetccg.nhs.uk

Explanation of Key Financial Terms (Table 18)

Term	Definition
Borrowings	Interest and other costs incurred in the borrowing of funds
Capital expenditure	The money spent on buying property, plant and equipment and intangible non-current assets, or adding to the value of existing non-current assets
Cash	Cash in hand and demand deposits
Cash equivalents	Short term, highly liquid investments that are readily convertible to known amounts of cash
Statement of cash	A summary of the cash paid and received by the Clinical

flows	Commissioning Group during the financial year
Current asset	An asset that is expected to be used or sold within an entity's operating cycle or within one year
Current liabilities	People/organisations to whom monies are owed by the Clinical Commissioning Group that are expected to be paid within one year or within an operating cycle
Depreciation	A charge to the Statement of Comprehensive Net Expenditure to reflect the cost of using property, plant and equipment and intangible non-current assets. It represents an allocation of the cost of such assets to the financial years in which they are used by the Clinical Commissioning Group
Employee benefits	All forms of consideration given in exchange for services rendered by employees
Gains	Increases in economic benefits
General fund	Represents tax payer's interest in the Clinical Commissioning Group.
Impairment	The loss in value of an asset arising from a specific event or valuation (this contrasts with depreciation, which recognises the reduction in value of an asset due to the passage of time or its use)
Intangible non-current asset	Assets that have no physical form, which provide benefit to the Clinical Commissioning Group over a number of years. In the case of the Clinical Commissioning Group they comprise licences for IT software
Inventories	Raw materials, work in progress and goods ready for sale
Property, plant and equipment	Assets that have physical form, which provide benefit to the Clinical Commissioning Group over a number of years. They include land, buildings, vehicles, equipment, IT hardware and furniture and fittings
Provision	A liability of uncertain timing or amount
Revaluation reserve	Certain property, plant and equipment non-current assets are recorded in the statement of financial position at a valuation (rather than original cost) to reflect the fact that their value can change over time. The revaluation reserve records the amount that has been recognised over time as net additional value for these assets
Revenue	The total income received for providing a product or service
Statement of comprehensive net expenditure	A summary of the costs incurred by the Clinical Commissioning Group during a financial year, net of miscellaneous revenue
Statement of financial	Summarises the financial position of the Clinical Commissioning

position	Group at a point in time in terms of the value of what it owns and what is owed to the Clinical Commissioning Group (assets) and how much it owes others (liabilities). It also shows the sources of finance used to fund the net of the assets and liabilities
Trade and other receivables	People and organisations who owe monies to the Clinical Commissioning Group
Trade and other payables	People and organisations who are owed monies by the Clinical Commissioning Group

PERFORMANCE

2.231 The performance delivered in respect of emergency and urgent care during the reporting period 1 April 2015 to 31 March 2016, for Somerset residents is set out below:

Emergency and Urgent Care Performance Scorecard between 1 April 2015 and 31 March 2016

Emergency Care	Standard	Achievement	Variance +/(-)
Cumulative percentage of patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95.00%	95.49%	0.49%
Percentage of ambulance handovers to A&E department within 30 minutes	100.00%	92.88%	(7.12%)
Percentage of ambulance handovers to A&E department occurring between 30-60 minutes	0.00%	6.65%	6.65%
Percentage of ambulance handovers to A&E department over 60 minutes	0.00%	0.46%	0.46%
Level of emergency admissions to increase by less than 1% annually	1.00%	8.02%	7.02%
Operations cancelled at the last minute offered another admission date within 28 days	100.00%	92.31%	(7.69%)
Percentage of people admitted directly to a stroke unit within 4 hours of hospital arrival	80.00%	62.02%	(17.98%)

2.232 The Clinical Commissioning Group is working with all providers to deliver these standards in 2016/17.

Ambulance Response Times

2.233 The performance of South Western Ambulance Service NHS Foundation Trust in achieving against the targets of 75% for all category A calls responded to within eight minutes and 95% for all category A calls

responded to within 19 minutes on a Trust-wide basis and across the NHS Somerset area, for the period 1 April 2015 to 31 March 2016 is set out below.

Percentage of Category A calls receiving a response from South Western Ambulance Service NHS Foundation Trust for the period 1 April 2015 to 31 March 2016

Standard	Target	Trust-wide Performance	Performance in Somerset
Within 8 minutes	75.00%	64.16%	61.74%
Within 8 minutes – life threatening cardiac calls (Red 1)	75.00%	73.72%	74.67%
Within 8 minutes – life threatening all non-cardiac (Red 2)	75.00%	63.60%	60.97%
Within 19 minutes	95.00%	89.44%	86.15%

2.234 South Western Ambulance Service NHS Foundation Trust did not achieve the 75% operational standard that all category A calls were responded to within eight minutes on a Trust-wide or Somerset basis. The Trust also did not meet the 95% operational standard that all category A calls were responded to within 19 minutes on a either a Trust-wide and Somerset basis.

2.235 Red 1 calls are the most time critical and cover cardiac arrest patients who are not breathing and do not have a pulse, and other severe conditions such as airway obstruction. Red 2 calls are serious but less immediately time critical and cover conditions such as stroke and fits. Red 1 patients account for less than 5% of all ambulance calls.

2.236 South Western Ambulance Service NHS Foundation Trust implemented a Red Performance Sustainability Plan during 2015-16. In addition, in response to the sustained increase in demand upon ambulance Trusts nationally and the impact upon the delivery of the response time targets, South Western Ambulance Service NHS Foundation Trust was one of two Ambulance Trusts who were selected to participate in a 'dispatch on disposition' pilot. This pilot facilitated the prioritisation of responses to Red 1 incidents by holding the dispatch of resources to patients who were likely to have lower acuity issues until the presenting complaint was established and resulted in delivery of the target on a cumulative basis for 2015-16.

Waiting Times for Cancer Treatment

2.237 The operational standards require the following standards to be attained:

- 93% of patients to be seen within two weeks of referral
- 96% of patients' first treatments to be within 31 days or less from the decision to treat

- 98% of patients second or subsequent treatments by anti-cancer drug treatments, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by surgery, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by radiotherapy, within 31 days or less from decision to treat
- 85% of patients' first definitive treatment will be within 62 days from urgent GP referral to their first definitive treatment
- 90% of patients' first definitive treatment will be within 62 days from cancer screening programme or consultant upgrade to their first definitive treatment

2.238 The performance scorecard in respect of the cancer waiting times standards achieved for services and Somerset patients, for the period 1 April 2015 to 31 March 2016 is shown below

Waiting Times Standard	Standard	April 2015 – March 2016	Variance
		Number inside standard	+/(-)
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93.00%	93.00%	0.00%
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93.00%	93.80%	0.80%
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96.00%	96.91%	0.91%
31-Day Standard for Subsequent Cancer Treatments-Surgery	94.00%	94.54%	0.54%
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98.00%	99.91%	1.91%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94.00%	97.93%	3.93%
62 day wait - % treated in 62 days from GP referral	85.00%	82.44%	(2.56%)
62 day wait - % treated in 62 days from screening programme	90.00%	90.50%	0.50%
62 day wait - % treated in 62 days from consultant upgrade	90.00%	88.12%	(1.88%)

Referral to Treatment Pathways

2.239 The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2015 to 31 March 2016 is set out below.

Somerset Clinical Commissioning Group Key Performance Scorecard (Somerset Relevant Population) between 1 April 2015 and 31 March 2016

Indicator		Standard	% Achieved	Variance +/(-)	Variance +/(-)
Referral to Treatment waiting times	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no less than 18 weeks from Referral	92.00%	92.18%	0.18%	0.18%
	Average Median waiting time (2015-16)	7.2 Weeks	6.36 Weeks	0.84 Weeks	0.84 Weeks
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99.00%	95.10%	-3.90%	(3.90%)

Referral to Treatment - Standards

2.240 Somerset Clinical Commissioning Group continues to monitor performance against a standard that requires 92% of patients to be treated within 18 weeks of referral and is working with all providers to deliver these standards in 2015/16.

Ambulance Conveyance Outcomes

2.241 The performance of South Western Ambulance Service NHS Foundation Trust of all responded calls and outcomes in Somerset, for the period 1 April 2015 to 31 March 2016, compared to the same period in the previous year is set out below.

Number of all calls receiving a response from South Western Ambulance Service NHS Foundation Trust (Somerset patients) and outcomes for the period 1 April 2015 and 31 March 2016, compared to the same period in the previous year.

Ambulance Conveyance Outcome	April 2014 to March 2015	April 2015-March 2016	Variance +/(-)	Variance %	Variance % +/(-)
Total Number Of Calls	84,938	86,770	1,832	2.16%	2.16%
Call Outcome - Hear & Treat	7,086	9,706	2,620	36.97%	36.97%
Call Outcome - See & Treat	30,529	29,160	(1,369)	-4.48%	(4.48%)
Call Outcome - See & Convey To All Destinations	47,288	47,904	616	1.30%	1.30%

2.242 The Clinical Commissioning Group is seeking to ensure that where appropriate, patients are not conveyed to hospitals where alternative care can be provided outside of hospital.

Infection Control

2.243 Performance in respect of infection control for the period 1 April 2015 to 31 March 2016.

Infection Control Performance between 1 April 2015 and 31 March 2016

Infection control		Annual Standard	Actual	Variance +/(-)
MRSA rates	Cumulative number of trust wide reported MRSA Bacteraemias	0	1	1
Clostridium Difficile rates	Cumulative number of trust wide reported CDAD	131	112	(19)

Notes:

1) 2015/16 MRSA and C. difficile data is provided on a commissioner basis and will include cases within primary and residential care, community and mental health hospitals and also acute trusts.
2) 2015/16 C. difficile actual (112) includes avoidable and unavoidable cases and Somerset patients treated out of county.

2.244 Somerset Clinical Commissioning Group's Infection Control Lead continues to seek assurance from the Trust that all necessary actions are being implemented to manage infection control performance.

Self Certification by the Accountable Officer

We certify that the Somerset Clinical Commissioning Group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

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

Signed:

David Slack

Accountable Officer

Somerset Clinical Commissioning Group

Date: 26 May 2016

3 ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

3.1 The membership of the Somerset CCG Governing Body and Leadership Team is set out in Table 25 below detailing names, roles and membership of the key committees within the CCG. There is a detailed breakdown of attendance at each of the committees plus a full list of member practices in Annex 1 to the Annual Governance Statement.

3.2 The CCG register of interests, which includes details of company directorships and other significant interests held by senior CCG leaders, is available on the CCG website at: http://www.somersetccg.nhs.uk/publications/publication-scheme/lists-and-registers/?Lists%20and%20Registers.

3.3 There have been no incidents regarding the loss of personal data that have required reporting to the Information Commissioner's Office.

3.4 Each CCG Director has confirmed to the Accountable Officer that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; that they have has taken all the steps necessary to make themselves aware of any such information and to establish that the auditors are aware of it.

Table 25: Breakdown of CCG Senior Leaders and their roles in the CCG governance structure

Name	Title	Committee Membership (voting and non-voting membership)						
		Governing Body	Clinical Operations Group	Audit Committee	Remuneration Committee	Governance Committee	Joint Committee (Primary Care)	Health and Well Being Board
CCG Executive Leadership								
David Slack	Managing Director/Accountable Officer	✓	✓			✓		✓
Alison Henly	Chief Finance Officer and Director of Performance	✓	✓			✓	✓	
Lucy Watson	Director of Quality, Safety and Governance	✓	✓			✓	✓	
Ann Anderson	Director of Clinical Commissioning Development	✓	✓			✓	✓	
Paul Goodwin	Director of Commissioning Reform	✓	✓					
Steven Foster	Director of System Transformation (joint role with Somerset County Council)		✓					✓
GP Practice Clinical Leadership								
Dr Matthew Dolman	CCG Chairman and GP Locality Delegate, Bridgwater Bay	✓	✓			✓		✓
Dr Ed Ford	Clinical Operations Group Chair and GP Locality Delegate, West Somerset	✓	✓			✓		✓
Dr Iain Phillips	GP Locality Delegate, South Somerset	✓	✓			✓		
Dr Stephen Gardiner	GP Locality Delegate, Bridgwater Bay		✓					
Dr Geoff Sharp	GP Locality Delegate, Central Mendip	✓	✓	✓				
Dr Emma Keane	GP Locality Delegate, East Mendip		✓					
Dr Mike	GP Locality Delegate, West		✓					

Name	Title	Committee Membership (voting and non-voting membership)						
		Governing Body	Clinical Operations Group	Audit Committee	Remuneration Committee	Governance Committee	Joint Committee (Primary Care)	Health and Well Being Board
Pearce	Mendip							
Dr Sarah Pearce	GP Locality Delegate, CLICK		✓					
Dr John Trepess	GP Locality Delegate, Taunton Deane		✓					
Trudi Mann	Practice Manager		✓					
Non-Executive Leadership								
Lou Evans	Vice Chair and Non-Executive Director, Governance and Audit	✓		✓	✓	✓	✓	
David Bell	Non-Executive Director and Chair of the Joint Committee (Primary Care)	✓		✓	✓		✓	
Eilleen Tipper	Non-Executive Director, Patient and Public Involvement	✓		✓	✓	✓	✓	
Dr Sean O'Kelly	Non-Executive Director, Secondary Care Specialist Doctor	✓				✓	✓	
Carolyn Moore	Non-Executive Director, Registered Nurse	✓		✓	✓	✓	✓	
Dr Trudi Grant	Director of Public Health, Somerset County Council	✓						✓

STATEMENT OF ACCOUNTABLE OFFICER'S RESPONSIBILITIES

3.5 The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Managing Director to be the Accountable Officer of the Clinical Commissioning Group.

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

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

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

Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

Make judgements and estimates on a reasonable basis;

State whether applicable accounting standards as set out in the *Manual for Accounts* issued by the Department of Health have been followed, and

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

Prepare the financial statements on a going concern basis.

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

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed:

David Slack

Accountable Officer

Somerset Clinical Commissioning Group

Date: 26 May 2016

NHS
Somerset
Clinical Commissioning Group

ANNUAL GOVERNANCE STATEMENT

Introduction and Context

3.6 The Somerset Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006. NHS Somerset CCG was successfully authorised without any conditions in December 2012 as part of the first wave of the CCG authorisation process.

3.7 As at 1 April 2015, the NHS Somerset Clinical Commissioning Group was licensed without conditions.

Scope of Responsibility

3.8 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 the CCG's Accountable Officer Appointment Letter.

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

Compliance with the UK Corporate Governance Code

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

3.11 For the financial year ended 31 March 2016, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.

The Clinical Commissioning Group Governance Framework

3.12 The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

3.13 Somerset CCG is a membership body comprising of 75 practices. Each practice has a delegate who represents that practice and practices are able to align themselves to a Commissioning Locality. A full list of Member Practices is attached as Annex 1 to the Governance Statement. Each Locality is represented by one delegate on the Clinical Operations Group (COG) which in turn nominates 4 of its membership to the Governing Body.

3.14 Somerset CCG established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: four GPs, a secondary care specialist doctor, a registered nurse, a Director of Public Health, three independent lay members, the Accountable Officer and Chief Finance Officer. Details of the membership and the attendance of those members are set out in Annex 2 to the Governance Statement.

3.15 Organisational structure and accountabilities are clear and well defined. Where capacity and/or capability gaps have been identified, actions are put in place with expected outcomes and timescales. Somerset CCG clearly articulates its values to stakeholders through its Commissioning Plan and associated strategies. The Organisational Development plan includes undertaking an annual Staff Survey, 360 degree stakeholder survey and developing actions to address issues for development.

3.16 The following committees have been established by the Governing Body:

a) Clinical Operations Group (COG)

b) Audit Committee

c) Governance Committee

d) Remuneration Committee

e) Joint Committee (Primary Care)

3.17 The remit of each committee is as follows:

Committee	Key roles and responsibilities
Clinical Operations Group (COG)	The COG acts as the main work group for the Governing Body, and through conducting its functions undertakes the following overarching roles:

	• ensuring that the care and safety of patients remains the highest priority • overseeing the quality of commissioned services – quality being defined as clinically effective, personal and safe care • advising the Governing Body on the development of commissioning strategies, strategic priorities and relevant day to day clinical commissioning issues • overseeing the achievement of the CCG's strategic priorities as defined and approved by the CCG's Governing Body • acting as the forum for discussion between the members and invited others about clinical commissioning matters • making recommendations to the Governing Body about issues of strategic concern or on those issues sitting outside its scope of decision making and limits of authority • making clinical commissioning decisions on behalf of the Governing Body, within the agreed scope of decision-making and limits of authority • working actively to promote the CCG's membership model and the voice and influence of member practices and patients
Audit Committee	The Audit Committee provides assurance to the Governing Body by reviewing the CCG's systems of financial reporting and internal control and ensuring that an effective programme of audit is in place. In particular: • the committee shall critically review the CCG's financial reporting and internal control principles and ensure an appropriate relationship with internal and external auditors, and counter fraud is maintained • the Committee shall review the work and findings of the external auditor and consider the implications and management's responses to their work • the Committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Governing Body • the Committee shall ensure that there is specialist counter-fraud information, guidance and service provision within the CCG and that policies and procedures for all work related to fraud and corruption are in place, as required by the Secretary of State's Directions and by the Counter Fraud and Security Management Service • the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG's activities (both clinical and non-clinical), that supports the achievement of the CCG's objectives • the Audit Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications to the

	governance of the organisation • the Committee shall request and review reports and positive assurances from officers and managers on the overall arrangements for governance, risk management and internal control • the Audit Committee shall review the Annual Report and Financial Statements before submission to the Board • the Committee should also ensure that the systems for financial reporting to the Governing Body, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board • where the Committee considers that there is evidence of ultra vires or improper actions, it shall report them to the Governing Body through its Chair
Governance Committee	The overarching aim of the Governance Committee is to ensure that effective and efficient controls are in place in order to deliver the principal objectives of Somerset CCG and in particular: • to ensure that services are provided in a fair and equitable manner, working with other stakeholders, to ensure that the delivery of services support individual aspirations and needs • to ensure that high standards of patient safety are embedded throughout the organisation and those organisations through which care is provided to the Somerset population • to ensure that the views of service users and carers are central to the development and commissioning of health services in order to respond to their needs and improve services • to ensure service users are treated with dignity and respect, recognising the diversity of their needs, expectations and beliefs • to ensure that care is provided with compassion in safe, clean environments that support health and wellbeing for service users • to ensure that the principles of good governance are embedded throughout the organisation • to ensure the effective design, implementation and operation of the anti-bribery and corruption initiatives
Remuneration Committee	The Committee shall make recommendations to the Governing Body on determinations about pay and remuneration for employees of the CCG (Accountable Officer, other officer members and senior employees) and people who provide services to the CCG (including salary, any performance-related elements/bonuses, other benefits including pensions and cars, and contractual terms and termination of employment). The Remuneration Committee shall make recommendations to the Governing Body on any proposed remuneration for individual COG Members for specific work in addition to their COG role. The Remuneration Committee is authorised by the Governing Body

	to obtain legal, remuneration or other professional advice as and when required, at the CCG's expense, and to appoint and secure the attendance of external consultants and advisors if it considers this beneficial. The Remuneration Committee is authorised to decide on the most appropriate action needed by the Governing Body in the achievement of its Terms of Reference.

3.18 The CCG agreed to take on joint commissioning responsibilities for primary care services with NHS England from April 2015. To enable this to take place, the CCG amended its constitution and established a Joint Committee with its own terms of reference which have both been approved by NHS England. The CCG appointed an additional Non-Executive Lay Member to its Governing Body with particular responsibilities in relation to chairing the Joint Committee and for overview of the primary care commissioning functions. The Joint Committee met four times during 2015/16. The remit of this Committee is shown below:

Joint Committee (Primary Care)	The Joint Committee has delegated powers of responsibility from the Governing Body to: • jointly commission primary medical services for the population of Somerset • make primary care commissioning decisions; • oversee the development and implementation of the primary care strategy and workplan • oversee implementation of the CCG statutory duty to improve the quality of primary care

3.19 During 2015/16, the CCG has utilised the tools developed by the Good Governance Institute to help assess the effectiveness of governance systems within CCGs. The CCG carried out a self-assessment with its Governing Body members, reviewed governance effectiveness during development sessions and used learning from audit and external best practice to further develop its systems of governance during 2015/16.

3.20 The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England. The CCG has participated in the NHS England CCG 360 degree Stakeholder Survey and will use this feedback to inform its development plans once available. From these assessments I am able to report that Somerset CCG has been regularly assessed as being an effective organisation.

3.21 There has also been self-assessment undertaken by the Governing Body and Leadership Team to review their effectiveness against the governance criteria developed by the Good Governance Institute and

NHS England. The results have been discussed at Governing Body Development sessions and have informed the development of the Assurance Framework and further work going forward.

3.22 The self-assessment revealed many positive views from the Governing Body and Leadership Team of the CCG's systems to support governance and internal control. In particular:

- Established and effective working relationships to support commissioning responsibilities
- Commitment to patient engagement which has been demonstrated as being effective
- Strong systems to support quality and safeguarding
- Good use of evidence and data to supporting commissioning plans and decisions
- Robust mechanisms for financial risk management and effective use of the Corporate Risk Register t support delivery and seek assurance on mitigating plans
- Strong performance and quality reporting which supports evidence of how the CCG meets its legal duties

The assessment identified some areas to build upon in the future including more horizon scanning and joint working at a strategic level with partners and as a Senior Leadership Team identifying how best to support the delivery of the strategic objectives and ensure good succession planning for the future.

3.23 The Internal Audit work programme has been reviewed via the Audit Committee and this work supports our review of governance processes such as the Assurance Framework, risk management procedures, conflicts of interest and hospitality reporting procedures, data security and business continuity. The audit programme, together with the subsequent work to improve systems where appropriate and scrutiny by our committees, supports my assurance that we have a sound system of governance and internal control in place.

The Clinical Commissioning Group Risk Management Framework

3.24 A clear understanding of the CCG key strategic objectives and a commitment to corporate governance will ensure that risk analysis and management are applied throughout the organisation.

3.25 The CCG Risk Management Framework is set out in the Risk Management Strategy and Policy. The Risk Management Strategy and Policy was reviewed and updated during 2015/16. This policy supports the adoption of an open culture where individuals are encouraged to

report adverse incidents and near misses, to ensure the CCG can use learning to continuously improve health services and the way in which these are commissioned to meet the needs of the population

3.26 The purpose of the Risk Management Strategy and Policy is to:

- demonstrate an organisational risk management structure that details all the committees / sub-committees / groups / forums which have shared responsibility for managing risk across the organisation
- approve and monitor the risk management programme and the CCG's policies and procedures for the management of risk
- outline the process which ensures that the Governing Body undertakes a regular review of the Corporate Risk Register and Assurance Framework to provide assurance that the Governing Body of the CCG can deliver the strategic objectives
- demonstrate the development of a system for the implementation of seamless risk management strategies, in all areas of the organisation, including business planning and planned developments
- identify within the Risk Management Strategy, the documentation and process, roles and responsibilities of the key individual(s) in post with responsibility for advising on and co-ordinating risk management activities
- identify within the Strategy documentation the respective roles, responsibilities and accountability undertaken by the executive, lead officers and non-executive leads for each area of risk
- identify the responsibilities of all managers and staff and their authority with regard to identifying, assessing and managing risk
- outline the process for risk assessment for all types of risk
- sets out the risk appetite of the CCG which is assessed against the its risk rating matrix

Risk Appetite

3.27 As part of the Somerset CCG risk management process, all risks identified are evaluated and given a risk level rating. The higher the risk level, the greater the likelihood and/or impact of that risk occurring.

3.28 The risk threshold for significant risks is defined by a risk rating of 12, and risks of 12 and above are reported to the CCG Governing Body. A significant risk may be defined as any risk which has been identified by the Governing Body as being potentially damaging to the organisation's objectives.

3.29 Risks in this category shall have individual action plans for risk treatment. Risks shall be proactively managed and reported on at intervals defined in

the action plan but as a minimum requirement quarterly to the Governance Committee and to the Somerset CCG Governing Body.

Systems of Internal Control

3.30 The CCG is committed to maintaining a sound system of internal control including risk management. By doing this, the organisation aims to ensure that they are able to maintain a safe environment for patients through the services it commissions, for staff and visitors, and to minimise financial loss to the organisation and demonstrate to the public that it is a safe, efficient and well led organisation.

3.31 The CCG has an Equality Impact Assessment Policy in place which provides the framework to ensure compliance with our statutory obligations under the Public Sector Equality Duty 2010 s149, and to identify any risks to the organization in the delivery of this. Equality Impacts are also assessed through the cover sheets for all reports that are presented to the Governing Body and other Committees of the CCG to ensure consideration of equality is integral to planning and implementation in the CCG, and through provision of equality impact assessments for all new policies and service and pathway changes to be commissioned.

3.32 The CCG has a Patient and Public Engagement Strategy in place that was revised and approved by the Governing Body in March 2016. There is a strong engagement network in place in Somerset through the Health Forums for each Commissioning Locality, a network of Patient Participation Group Chairs and regular events to seek the views of patients and the public. There has been active engagement, in particular concerning the Somerset Together project and other key service consultations such as the Shepton Mallet Health Campus.

The Clinical Commissioning Group Internal Control Framework

3.33 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.

3.34 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.

3.35 All reports presented to the Governing Body include identified risks. All strategic documents are reviewed by the Clinical Operations Group and clinical risks to delivery considered. The effectiveness of the Committee Structure is continually reviewed internally via the Governing Body review programme and against best practice where available.

3.36 The Governing Body is engaged with, and has a clear understanding of the CCG's Five Year Strategy which was approved by the Governing Body in June 2014, and the key pressures facing the organisation. Following approval of the CCG Five Year Strategy, the CCG Assurance Framework was revised to reflect the changes to the CCG's revised strategic objectives and principal risks to delivery. There has been further consideration during 2015 – 16 of the risks to delivery of the CCGs strategic objectives through the Somerset Together Outcomes Based Commissioning programme. The CCG Governing Body reviews the organisational compliance and delivery of the strategic objectives against the Assurance Framework and Corporate Risk register on a quarterly basis.

3.37 Attendance at the Governing Body is recorded in the minutes and full membership of the Governing Body has been present at the majority of the Governing Body meetings and seminars during 2015/16.

3.38 Regular reports are presented to the Governing Body to provide assurance on all CCG business and include:

- strategic planning
- financial management
- patient safety and quality of clinical care
- Care Quality Commission inspection reports
- organisational development
- performance management and the achievement of national and local NHS targets
- patient engagement
- stakeholder engagement
- emergency planning
- compliance with the NHS constitution
- identified risks and actions to address or mitigate the risks
- development of clinical commissioning

3.39 The Governing Body's performance, effectiveness and capability is subject to continuous assessment, including quarterly assurance meetings with NHS England.

Information Governance

3.40 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.

3.41 We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and

corporate information. We have established an Information Governance Management Framework, which was refreshed and approved by the CCG Leadership Team in March 2016, and have put in place information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have provided guidance as appropriate to ensure staff are aware of their information governance roles and responsibilities. 97% of all staff had completed their information governance training by 31 March 2016.

3.42 The Health and Social Care Act 2012 provides the Health and Social Care Information Centre (HSCIC) with powers to collect personal confidential information. However, the act does not provide for the onward disclosure of identifiable data from the HSCIC. A national solution was agreed through the establishment of a network of Data Management and Integration Centres (DMICs), where only named staff can control access to identifiable data, with the NHS Information Centre having the oversight to manage all patient data. South West Commissioning Support Unit (SWCSU) operates a DMIC to cover Somerset, Bristol, North Somerset and South Gloucester CCGs.

3.43 Underpinning this arrangement the CCG and SWCSU have developed a data processing agreement, which supports the CSU carrying out actions on behalf of the CCG. This ensures that the CSU will maintain the personal data on behalf of the CCG in a confidential manner, to ensure that:

- personal data will only be used if necessary
- when necessary to process personal data, the minimum amount of personal data will be used
- processing of personal data will only take place where there is a legal basis for the use of such data
- access to personal data will only be provided on a strict need to know basis
- use for any activity outside the current remit of a service specification will require specific approval from the CCG Caldicott Guardian, who may take such requests to the Governance Committee within the CCG

3.44 There are processes in place for incident reporting and the investigation of serious incidents in relation to information governance. We have a process in place for the assessment of information risk and are continually developing our management procedures and a programme is being established to fully embed an information risk culture throughout the organisation.

Pension Obligations

3.45 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.

Equality, Diversity and Human Rights Obligations

3.46 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. The Governing Body approved a refreshed Equality and Patient Engagement Strategy in March 2016 which sets out how the organisation manages its obligations. The implementation of the strategy is monitored through the Governance Committee.

3.47 Each paper considered by the Governing Body and COG has had an impact assessment undertaken for any equality and diversity considerations.

Sustainable Development Obligations

3.48 The CCG adopted the plans that were put in place by Somerset Primary Care Trust and have continued to ensure that our planning encompasses the assessment of risks and, wherever possible, to enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. The CCG, as a tenant of the Wynford House offices, works with NHS Property Services to ensure the sustainability of the building is optimised.

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

3.50 The CCG has continued to support its commitments as a socially responsible employer. This includes initiatives to:

- support the cycle to work scheme which also helps to improve the health and well-being of staff
- help the national NHS target of reducing carbon emissions through employee travel
- work with the waste management service provider to increase the amount of recycled materials
- reduce the use of printers and consumables and promote a paperless environment
- continue to integrate the principles of sustainability across the organisation

Risk Assessment in Relation to Governance, Risk Management and Internal Control

3.51 The CCG has an approved Risk Management Strategy and Policy which has been reviewed during 2015/16. The Strategy sets out the framework that is in place to assess and manage risk, notably through the:

- Assurance Framework
- Risk Register
- Risk Assessment Framework
- Incident Reporting and Complaints Management Processes

3.52 The principal risks and the actions being taken to mitigate them have been reported on a quarterly basis to the Governing Body and in addition managed through the Governance Committee.

3.53 The CCG recognises that the strategic benefits to be achieved through risk management which includes:

- improved corporate decision making through the high visibility of risk exposure, both for individual activities and major projects, across the whole of the organisation

- a progressive management style and a culture of continuous improvement that is enhanced by the encouragement of openness in relation to risk

- the objectives of the organisation and its stakeholders are more likely to be realised through the early identification and proactive management of threats to cost, time and performance

- the needs of corporate governance are met by embedding the management of risk processes which provide a clear message and directives

- there is a clear ownership and accountability for risks and their management so that they are effectively monitored and proactively managed

- financial benefit to the organisation through improved "value for money" potential and better management of project and programme finance

- management of project risk is carried out within the wider context of programmes, thus minimising the risk of individual project failure through greater visibility of the potential impact of other projects

- consistency of approach through high-level monitoring and direction

- creation of an environment for the conscious acceptance of business risk on an informed basis

- improved contingency plans and business continuity plans
- better awareness in all personnel of the cost and benefit implications of their actions

3.54 The following methods are to be used in the identification and management of risk:

- maintenance of an organisation wide risk register
- involvement of all staff in the assessment of risk
- ongoing analysis of risk
- identifying new risks from significant events and near misses
- root cause analysis of significant events and serious untoward incidents
- identifying new risks from national reporting e.g. Central Alert System (CAS), Medicines and Healthcare Products Regulatory Agency (MHRA)
- NHS Litigation Authority risk pooling schemes and associated reporting

3.55 The CCG has established a governance structure to ensure that risks are being managed at the appropriate level as required by the terms of reference for each committee

3.56 The CCG is authorised to establish their own committees and sub-committees as detailed earlier in the document.

3.57 The overall CCG committee level responsibility for risk management rests with the Governance Committee. Other CCG groups with responsibility for risk management are the:

- Audit Committee
- Clinical Operations Group
- Leadership Team
- Patient Safety and Quality Assurance Committee
- Health and Safety Steering Group
- Information Governance and Health Records and Caldicott Committee

3.58 Staff are involved in risk management, both through the incident reporting process and the proactive management of risk which includes risk management issues identified on agendas, reports and the cover sheets that are presented to the respective Committees.

3.59 The CCG risk and control framework is based on the methodology and principles outlined in the publications:

- Integrated Governance Handbook 2006
- A risk matrix for risk managers – NPSA January 2008
- The Intelligent Board 2010
- Good Governance Institute – Good Governance Outcomes for CCGs toolkit 2015

3.60 The CCG procedural documents support the risk management and assurance processes and these include:

- Risk Management Strategy and Policy
- Serious Untoward Incident Policy
- Being Open Policy
- Standards of Business and Managing Conflicts of Interest Policy
- Acceptance of Gifts, Hospitality and Commercial Sponsorship Policy
- Incident Reporting Policy
- Strategy for Improving Health and Health Inequalities
- Equality and Diversity, Human Resources and Patient Engagement Strategy
- Sustainability Development and Carbon Management Strategy
- Emergency Planning and Resilience Policy
- Incident Response Plan
- Business Continuity Plan
- Urgent and Emergency Care Strategy
- Fraud Response Plan
- CCG Constitution incorporating the Standing Orders, Scheme of Delegation and Standing Financial Instructions
- Security Management Policy
- Health and Safety Policy
- Whistleblowing (Raising Concerns) Policy

3.61 At 31 March 2016 there were five risks on the Corporate Risk Register with a red rated retained risk (red risks are those scored over 12 using the CCG risk assessment matrix).

3.62 Four of the risks relate to anticipated pressures in 2016/17 regarding the:

- delivery of the CCG's budget and surplus
- meeting the QIPP targets
- achievement of the 18 week referral to treatment target at Taunton and Somerset Foundation NHS Trust
- movement to full payment by results contracts at both acute Foundation NHS Trusts and possible impact on activity figures

3.63 The other red rated risk relates to the medical staffing in the Emergency Department in Weston District General Hospital. Following an external review Junior Doctors were removed from night and weekend provision in

the Emergency Department and staffing cover is being provided locums and by other local Trusts.

3.64 The remaining 16 risks on the Corporate Risk Register were all scored as amber (rating of 12). One of these risks had an initial red rating, however the controls being implemented have been sufficient to mitigate those risks effectively and reduce it to an amber rating. The Governing Body and Clinical Operations Group are updated regularly through the performance report and balanced scorecard. The risk in question related to the substantial new Somerset Together project and the development of the 'most capable provider' process.

3.65 The CCG is working closely with the Local Authority through the Health and Well Being Board and any risks relating to that work and, in particular, the management of pooled budgets and the Better Care Fund are being managed through the Directorate level relationships between the CCG and Local Authority. A new Directorate structure has been developed within the CCG to support the management of this important work stream.

3.66 The Corporate Risk Register sets out the actions in place to mitigate the risks and is reported to the CCG's Governance Committee and Governing Body every quarter.

Review of Economy, Efficiency and Effectiveness of the use of Resources

3.67 The Audit Committee is responsible for seeking assurance and overseeing Internal and External Audit and Counter Fraud services, reviewing financial and information systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments. The Committee reviews the system of governance, risk management and internal control, across the whole of the organisation's activities.

3.68 During 2015/16, the Audit Committee undertook an assessment against the self assessment checklist contained in the HFMA Audit Committee Handbook. This focused on the quality and financial experience of the members and the work programmes undertaken to ensure it provided assurance across the range of CCG responsibilities. From this a work programme was developed in 2016/17

3.69 The Audit Committee receives regular reports from Internal and External Audit, Counter Fraud and the Governance Committee.

3.70 The Audit Committee supports the view that fraud against the NHS will not be tolerated. All genuine suspicions of fraud are investigated and if proven the strongest sanctions are sought against the perpetrators.

3.71 As well as overseeing the anti-fraud, bribery and corruption arrangements in place within its providers, the CCG also needs to ensure its own counter fraud measures remain robust. Somerset CCG has well

established counter fraud arrangements in order to help the organisation achieve the standards set out by NHS Protect. The CCG engages an Accredited Counter Fraud Specialist to implement an on-going programme of anti-fraud, bribery and corruption work across the whole organisation. During 2015/16 work has involved the delivery of an annual work plan which follows NHS Protects strategy to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all 4 key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

3.72 Somerset has historically taken a very robust approach to counter fraud work, the Local Counter Fraud Specialist (LCFS) is well resourced in terms of work plan days and the Audit Committee and senior management throughout the organisation understand the importance of counter fraud work and fully support the LCFS and Chief Finance Officer and Director of Performance in conducting that work.

3.73 The LCFS has developed key relationships with the following teams/directorates, Human Resources, Recruitment, Payroll, Risk Management and Communications. These relationships coupled with the significant work done by the LCFS to develop an anti-fraud culture have resulted in good quality referrals being made to the LCFS. This in turn has resulted in a good proportion of cases concluding in civil, criminal and/or disciplinary sanctions. Where possible these sanctions are publicised within the organisation to give staff confidence that robust action is taken when allegations of fraud are made, this also has a significant deterrence effect on other employees and prevents other incidents of fraud.

3.74 During 2015/16 two referrals were received raising concerns about named patients attending GP surgeries in order to obtain prescription drugs. These cases could not be progressed criminally and in one case no financial loss could be identified. Recommendations were made to strengthen existing procedures in GP surgeries to help prevent fraud and future abuse.

3.75 The Clinical Commissioning Group is working with local NHS Foundation Trusts to implement findings from the Carter Review to deliver a more effective and efficient NHS in Somerset.

3.76 The Clinical Commissioning Group continues to set a challenging QIPP programme, which sees planned QIPP savings of £26.9m within the 2016/17 financial plan. These QIPP schemes are vigorously monitored through the Programme Management Office to ensure key risks and issues are identified and decisions taken at the Leadership Team where required. Through the Sustainability and Transformational Planning meetings local leaders continue to discuss QIPP/CIP assumptions to ensure a robust peer challenge is in place across Somerset, but to also

confirm clear assumptions are in place to ensure no double counting across organisations.

3.77 The Clinical Commissioning Group is looking at all opportunities for cost savings in year and as part of this is reviewing the information in the Right Care pack and Better Care Better Value benchmarking information. The focus is on the schemes that will deliver during 2016/17.

3.78 To support this, the Clinical Commissioning Group has set up a finance group chaired by the Interim Chair of the CCG which is looking at the financial position and QIPP opportunities across the range of services commissioned. This group meets fortnightly to review the position and has an active work programme which is being actioned through the Clinical Commissioning Group Leadership team.

3.79 The Clinical Commissioning Group is also responding to the challenges of changing population demographics, financial austerity and public expectations of the health services through its commitment to an alternative approach to Commissioning through Somerset Together. This offers providers the incentives to collaborate and integrate the delivery of care around the individual and provides the means to improve outcomes that matter to the people using services. The Clinical Commissioning Group, with the Provider Organisations and Somerset County Council, are looking at the financial challenge through the Sustainability and Transformational Planning with 2016/17 setting the scene for the 5 year plan moving forward.

The Better Care Fund

3.80 In 2015/16 the Better Care Fund (BCF) was established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It was a requirement of the BCF that NHS Somerset CCG and Somerset County Council established a pooled fund for this purpose, which was achieved in 2015/16 through a signed agreement under Section 75 of the National Health Service Act 2006.

3.81 The NHS Somerset CCG and Somerset County Council working together with the Health and Wellbeing Board have agreed BCF plans that enable the CCG and its partners to deliver better outcomes for the people of Somerset through fully integrated, person-centric and seamless health and social care services.

3.82 Somerset's approach to the BCF has been to identify schemes which both commissioners and providers are able to agree to within the challenges of the BCF funding already being largely committed to.

3.83 The BCF Plan meets each of the national conditions for the BCF as set out in the Better Care Fund Policy Framework:

- plans are jointly agreed
- maintains the provision of social care services
- agreement for the delivery of selected 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate
- better data sharing between health and social care, based on the NHS number
- ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans
- agreement to invest in NHS commissioned out-of-hospital services which may include a wide range of services including social care
- agreement on a local target for Delayed Transfers of Care (DTOC)

3.84 The Somerset Better Care Fund has four schemes, with a number of overarching system enabling projects to be undertaken, that are aligned with the national conditions. All of the schemes and projects developed in 2015 promote integrated working as set out below:

- Scheme A - Continue to Invest in Reablement
- Scheme B - Joined-up Person-centric care
- Scheme C - Improved Discharge to Home Arrangements
- Scheme D - Housing Adaptations

3.85 Success is measured through the existing national measures, for example:

- effectiveness of reablement - Reduce unplanned admissions and readmissions to hospital
- delayed transfers of care - Reduce hospital length of stay by enabling people, who no longer require acute medical intervention, to have a timely discharge from hospital
- admissions to residential and care homes - Reduce demand for domiciliary care and residential/nursing care

- patient/service user experience - Deliver improvement in an Individual's quality of life

3.86 The Health and Wellbeing Board, the Joint Commissioning Board and the Pooled Fund Management within the NHS CCG and Somerset County Council have provided the necessary Governance arrangements for:

- the day to day operation and management of the Pooled Fund
- ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of the Section 75 Agreement and the relevant Scheme Specification
- maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund
- ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the Section 75 agreement
- reporting to the Joint Commissioning Board as required, the BCF Guidance and the relevant Scheme Specification
- preparing and submitting to the Joint Commissioning Board Quarterly reports and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Commissioning Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met. Detailed monitoring of expenditure was completed through the Joint Commissioning Board finance Sub Group
- preparing and submitting reports to the Health and Wellbeing Board as required by it which shall include the submission of copies of the Quarterly and Annual reports to the Joint Commissioning Board

Review of the Effectiveness of Governance, Risk Management and Internal Control

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

Capacity to Handle Risk

3.88 Leadership is given to the risk management process led by the Director of Quality, Safety and Governance supported by all members of the Leadership Team.

3.89 Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. Guidance is provided to staff through a variety of routes including training, updates through bulletins and learning through incidents.

Review of Effectiveness

3.90 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the 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 the External Auditors in their management letter and other reports.

3.91 The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed and there are actions in place to mitigate risks and address gaps in controls. The format of the Assurance Framework has been developed during 2015/16 to build upon best practice and audit review and has further enhanced the effectiveness of the tool for the Governing Body.

3.92 I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and Governance Committee, and a plan is in place to ensure continuous improvement of the system.

3.93 The Audit Committee received the Head of Internal Audit's report on the Assurance Framework as part of the internal audit programme 2015/16. No significant issues or gaps in assurance were identified in the CCG risk management and assurance systems or processes within the audit. The findings of the audit concluded there was moderate assurance for both design and operational effectiveness. The Governing Body can take substantial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective.

3.94 The CCG has ensured that internal controls have been monitored and reviewed in the year, by:

- External and Internal Audit reports and action plans are submitted to the Audit Committee on a regular basis, with the minutes and action reported to the Governing Body

- reports made by the Local Counter Fraud and Security Management service on proactive investigations, suspected frauds or irregularities within the Trust or within the country which may have an impact upon the trust, again submitted to the Audit Committee on a regular basis, with the minutes and actions reported to the Governing Body

- developing and maintaining an Assurance Framework, with officers identifying key controls relied upon and an action list where risks remain

- active assessment and mitigation of risk which is monitored and reviewed by the Governance Committee through the Corporate Risk Register, with minutes reported to the Governing Body

- monitoring and investigating complaints - which are reported at the Governance Committee, with minutes and action plans reported to the Governing Body. Issues about risks and systems are actioned by appropriate lead officers

- monitoring issues arising from the Patient Advice and Liaison Service (PALS) and the impact these may have on systems and internal controls. Issues are reported regularly to the Governance Committee

- monitoring and investigating serious untoward incidents and reporting on the lessons learned and implementation of action plans

- monthly reporting of the financial position of the CCG to the Governing Body

- monthly reporting to the Governing Body and the Clinical Operations Group of the performance position against principal national and local targets

- weekly meetings of the Leadership Team to discuss performance and key requirements of the organisation, including risk management and internal controls

- the Governance Committee receives reports on progress against actions planned against identified risk across the organisation. It is the responsibility of all Directors to progress identified actions in accordance with the Risk Register and associated action plans

Head of Internal Audit Opinion

3.95 Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management,

governance and internal control. The Head of Internal Audit concluded that:

Head of Internal Audit Opinion

The role of internal audit is to provide to the Governing Body, through the Audit Committee, assurances on the adequacy and effectiveness of the system of internal to ensure the achievement of the organisation's objectives in the areas reviewed.
This interim report provides an indicative Head of Internal Audit opinion on the organisation's risk management, control and governance processes, within the scope of work undertaken in FY16 to date by our firm as outsourced providers of the internal audit service.
Opinion

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Frame work and supporting processes
- An assessment of the range of individual opinions arising from risk based audit assignments contained within internal audit risk based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
- Any reliance that is being placed upon third party assurances

Overall, we are able to provide **moderate assurance** that there is a sound system of internal control designed to meet the CCG's objectives and that controls are being applied consistently. Moderate assurance is our second highest assurance rating and, under the previous NHS internal audit standards, is equivalent to the following: significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

In forming our view we have taken into account that:

- The CCG remains financially sound and is forecasting a year end surplus of £6.5m
- We noted that as at April 2016 the CCG had made good progress in implementing outstanding audit recommendations, with 13/15 completed
- One limited assurance opinion has been awarded, in relation to IT project management

While we have given moderate assurance, there is a higher number of substantial opinions than last year, indicating an improvement in the control environment and a move towards substantial assurance (our highest rating).
It should be noted that our opinion is restricted to work we have performed on the CCG's controls; the CCG will need to consider the service auditor report on the Commissioning Support Unit (CSU) when drafting its Annual Governance Statement.

3.96 During the year the Internal Audit issued the following audit report with a conclusion of limited assurance.

IT (SIDeR Portal Development Programme)	Summary of Report: A review to provide assurance in relation to the project management controls operating over Phase 1 of the Portal Development project, part of the Somerset Integrated Digital e-

	Record (SIDeR) programme, noted good practice in terms of the submitted business case to NHS England's Vanguard programme, the implementation of the information sharing agreement and EMIS Viewer and stakeholder arrangements in place. However, three high risk recommendations were raised to identify a source of funding for the acquisition and implementation of the Portal records sharing system, that the scope of the project had not been defined in the project mandate or project initiation document and that business process mapping had not been undertaken to define end user requirements of the Portal records sharing system. A further three medium risk recommendations were raised in relation to adequate senior managerial and stakeholder oversight, the lack of a detailed project plan or dedicated project team and project risks and issues management processes not being robust enough. Action Being Undertaken: • The programme has been relocated into the newly formed System Transformation Directorate and approval to recruit a dedicated Programme Manager has been given. As part of the role this post holder will have a number of responsibilities around budget management; identifying and agreeing sources of funding for the programme (commensurate with a clearly defined and agreed purpose and strategy), managing the programme budget and ensuring appropriate reporting procedures-the identification and mitigation of financial risk. • The post will also lead on the project management aspects of SIDeR; developing and agreeing project mandate and PID which will cover the scope , current infrastructure benefits and benefits realisation process as well as the impact on OBC (short and medium term). This work has begun with a stock take of the current position-using this audit, elements of the Digital Road Map Self-Assessment and 1:1 discussions with key partners. • The Project Initiation document will include the requirements to define and deliver appropriate business mapping exercises as well as the establishment of a clinically driven end user specification. This work (both the development of the PID-and delivery against it) will be co-ordinated by the programme manager utilising the experience and expertise of all partners within the programme. • The project initiation document will include an agreed governance framework across all of the partners supported by Terms of Reference. This will include appropriate

	reporting mechanisms around programme progress risks and mitigation. • The project manager will be tasked with the development of a project plan covering the whole programme including governance arrangement as previously described user acceptance testing and training. This plan (and progress against this plan) will be regularly reviewed by the post holder, their line manager the proposed SIDeR Programme Board. Significant escalations will be made via the System Leadership group comprising the Chief Executives of all core partners. • The project initiation document will describe the governance process which will include the regular production of a comprehensive and timely risk and issues log forming part of the reporting to the stakeholders through the SIDeR programme board.

3.97 During the year the Internal Audit did not issue any audit reports with a conclusion of no assurance.

Data Quality

3.98 The CCG has continued to develop data quality in conjunction with the CSU during the 2015/16 financial year.

Business Critical Models

3.99 The CCG uses a number of models to support operational management, however none of these models are business critical.

Data Security

3.100 Somerset CCG have submitted a satisfactory level of with the Information Governance (IG) Toolkit with an overall compliance rate of 75% for 2015/16 which is an increase from 72% in 2014/15. The clinical commissioning group has no requirements assessed as Level 0 or Level 1, seventeen at Level 2, six at Level 3 and five 'Not Relevant'. Particular improvement to Level 3 status was made in areas including monitoring of Smartcard usage and Business Continuity Planning, while at the same time maintaining previously achieved Level 3 requirements. The level of compliance reflects the sustained progress building upon the information governance structures and processes established during the first two years of the CCG's establishment and provides a robust assessment of the progress to date. An improvement plan is in place to ensure that the work continues to develop and that compliance further improves during 2016/17 which will be monitored through the Information Governance, Records Management and Caldicott Committee.

3.101 No lapses in data security for the CCG were reported during the year. Any information breaches are assessed and where appropriate, reported through the Information Governance (IG) Toolkit, as set out in the Health and Social Care Information Centre 'Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation, version 5.1, May 2015'. As there is no link between the IG toolkit and the Strategic Executive Information System (STEIS), IG level 2 incidents will also need to be reported on STEIS.

Discharge of Statutory Functions

3.102 Arrangements put in place by the CCG and explained within the Constitution, have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation. The Constitution has been updated during 2015/16 with appropriate legal advice and approval by NHS England to reflect the changes to the organisational structure and responsibilities to be taken on from the 1 April 2015 for Joint Commissioning of Primary Care services. Further changes will be incorporated during 2016/17 to take account of the governance arrangements required to support the formation of the Somerset Together Programme Board.

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

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

CONCLUSION

3.105 My review confirms that Somerset CCG has a generally sound system of internal control that supports the achievement of its policies, aims and objectives and that no significant internal control issues have been identified.

Signed:

David Slack

Accountable Officer

Somerset Clinical Commissioning Group

Date: 26 May 2016

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG for 2015/16 are listed below grouped within their Commissioning Locality.

Bridgwater Bay Health
- Quantock Medical Centre
- Cannington Health Centre
- East Quay Medical Centre
- Victoria Park Medical Centre
- Taunton Road Medical Centre
- Cranleigh Gardens Medical Centre
- Redgate Medical Centre
- Somerset Bridge Medical Centre
- North Petherton Surgery
- Edington Surgery, Quarry Ground

Central Mendip
- Oakhill Surgery
- Grove House Surgery
- Park Medical Practice

Chard, Crewkerne and Ilminster
- West One Surgery
- Summervale Surgery
- Essex House Medical Centre
- The Meadows Surgery (Ilminster)
- Springmead Surgery
- Tawstock Medical Centre
- Church View Surgery
- North Street Surgery (Langport)

East Mendip
- Mendip Country Practice
- Beckington Family Practice
- Frome Medical Practice

North Sedgemoor
- Burnham and Berrow Medical Centre
- Brent Area Medical Centre
- Axbridge and Wedmore Surgeries
- Cheddar Medical Centre
- Highbridge Medical Centre

Taunton and Area
- North Curry Health Centre
- Creech Medical Centre
- Blackbrook Surgery
- Warwick House Medical Centre
- College Way Surgery

- Victoria Gate Surgery
- St James Medical Centre
- French Weir Health Centre
- Crown Medical Centre
- Lyngford Park Surgery
- Quantock Vale Surgery
- Lister House Surgery
- Luson Surgery
- Wellington Medical Centre

South Somerset Healthcare
- Bruton Surgery
- Millbrook Surgery
- Wincanton Health Centre
- Milborne Port Surgery
- Queen Camel Medical Centre
- Somerton Surgery
- Ilchester Surgery
- Ryalls Park Medical Centre
- Oaklands Surgery
- Penn Hill Surgery
- Hendford Lodge Medical Centre
- Preston Grove Medical Centre
- Abbey Manor Medical Practice
- Yeovil Health Centre
- Westlake Surgery (Dr Day)
- Westlake Surgery (Dr Smith)
- Hamdon Medical Centre
- Church Street Surgery
- Crewkerne Health Centre

West Mendip
- Wells City Practice
- Wells Health Centre
- Glastonbury Surgery
- Glastonbury Health Centre
- The Vine Surgeries (Vriend)
- The Vine Surgeries (Wolfe)

West Somerset
- West Somerset Healthcare
- Porlock Medical Centre
- Irnham Lodge Surgery
- Harley House Surgery
- Exmoor Medical Centre
- Dunster Surgery
- Brendon Hills Surgery

Annex 2 (Governance Statement)

Somerset CCG Governing Body Meetings 2015/16 – Attendance Record								✓ = Present X = Apologies Given		
(V) = voting Member (NV) = non-voting Member	30 April 2015	28 May 2015	16 July 2015	17 Sept 2015	22 Oct 2015	19 Nov 2015	17 Dec 2015	28 Jan 2016	25 Feb 2016	31 Mar 2016
Dr Matthew Dolman (V) Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ann Anderson (NV) Director of Clinical Commissioning Devt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Bell (V) Non-Executive Director and Chair of the Joint Committee (Primary Care)		✓	✓	✓	X	✓	✓	✓	X	✓
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	X	✓	✓	✓	X	✓	✓	✓
Dr Ed Ford (V) Chair of the Clinical Operations Group	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Paul Goodwin (NV) Director of Commissioning Reform			✓	✓	✓	X	✓	✓	X	✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Alison Henly (V) Chief Finance Officer and Director of Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Sean O'Kelly (V) Non-Executive Director, Secondary Care Specialist Doctor	X	✓	✓	✓	✓	✓	X	X	✓	X
Carolyn Moore (V) Non-Executive Director, Registered Nurse	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Dr Iain Phillips (V) GP	X	✓	X	✓	✓	✓	✓	X	✓	✓
Peter Rowe (NV) PPG Lay Observer	✓	✓	X	✓	X	✓	✓	✓	X	✓
Dr Geoff Sharp (V) GP	✓	✓	✓	✓	✓	✓	X	✓	✓	X
David Slack (V) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Eilleen Tipper (V) Non-Executive Director, PPE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lucy Watson (NV) Director of Quality, Safety and Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Harry Yoxall (NV) Local Medical Committee (Observer)	✓	✓	✓	✓	✓	✓	✓	X	X	✓

Somerset CCG COG Meetings
2015/16 – Attendance Record

✓ = Present
X = Apologies Given

(V) = voting Member (NV) = non-voting Member	1 April 2015	13 May 2015	10 June 2015	8 July 2015	5 Aug 2015	2 Sept 2015	7 Oct 2015	4 Nov 2015	2 Dec 2015	3 Feb 2016	2 Mar 2016
Dr Ed Ford (V) COG Chair and West Somerset Health Locality Delegate	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Stephen Gardiner (V) COG Vice Chair and Bridgwater Bay Health Locality Delegate	✓	X	✓	✓	✓	X	✓	✓	✓	✓	✓
Dr Matthew Dolman (V) North Sedgemoor Locality Delegate	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Dr John Trepess (V) Taunton Deane Locality Delegate	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X
Dr Emma Keane (V) East Mendip Locality Delegate	✓	X	✓	✓	✓	✓	X	✓	✓	✓	✓
Dr Sarah Pearce (V) Chard, Crewkerne and Ilminster Locality Delegate	✓	✓	✓	X	✓	✓	X	✓ (ED)	✓ (ED)	X	X
Dr Iain Phillips (V) South Somerset Locality Delegate	✓	✓	✓	X	✓	✓	X	✓	✓	X	✓
Dr Geoff Sharp (V) Central Mendip Locality Delegate	✓	X	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Michael Pearce (V) West Mendip Locality Delegate	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Lisa Wallis (V) Practice Manager Delegate (until 20/7/15)	X	✓	✓	X							✓
Trudi Mann (V) Practice Manager Delegate										✓	✓
David Slack (V) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer, Director of Performance	✓ (DH)	✓	✓	✓	✓ (DH)	✓	✓ (DH)	✓	✓	✓	✓
Lucy Watson (V) Director of Quality, Safety and Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓ (DR)	✓	X
Ann Anderson (V) Director of Clinical and Collaborative Commissioning	✓	✓	✓	✓	✓	✓	✓	✓	✓ (TW)	✓	✓

(V) = voting Member (NV) = non-voting Member	1 April 2015	13 May 2015	10 June 2015	8 July 2015	5 Aug 2015	2 Sept 2015	7 Oct 2015	4 Nov 2015	2 Dec 2015	3 Feb 2016	2 Mar 2016
Stephen Chandler (V) Director of Social Services Somerset County Council										✓	✓
Dr Nick Bray (NV) GP & LMC Representative	✓	✓	✓	✓	✓	✓	✓ (KS)	✓	✓	X	✓
Chris Simpson (NV) Lay Member (until 31/7/15)	✓	✓	✓	✓							
Peter Hillman (NV) Lay Member (from 1/8/15)		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Glanfield (NV) Head of Service Development and Clinical Engagement		✓		✓		✓		✓		✓	✓
Andrew Hill (NV) Head of Locality Commissioning	✓		✓		✓		✓		X		
Steven Foster (NV) Director of Transformation										✓	✓

Initials in brackets indicate deputising arrangements as follows:
TW – Tanya Whittle for Ann Anderson
ED – Emeline Dean for Sarah Pearce
DR – Debbie Rigby for Lucy Watson
KS – Karen Sylvester for Nick Bray
DH – Deborah Hillier for Alison Henly

AUDIT COMMITTEE Meetings 2015/16 – Attendance Record

Somerset CCG Audit Committee Meetings 2015/16 – Attendance Record

✓ = Present
X = Apologies Given

Name	**Member (M)/ In Attendance (A)**	**21 May 2015**	**23 Sept 2015**	**9 Dec 2015**	**17 Feb 2016**
Lou Evans Audit Committee Chair	M	✓	✓	✓	✓
David Bell Non-Executive Director	M		✓	✓	✓
Carolyn Moore Registered Nurse	M	✓	X	✓	✓
Dr Geoff Sharp GP Member	M	✓	✓	✓	X
Eilleen Tipper Non-Executive Director	M	✓	✓	✓	✓
Alison Henly Chief Finance Officer and Director of Performance	A	✓	✓	✓	✓

Representatives from External and Audit Internal and Counter Fraud were present at meetings throughout the year, with other representatives attending as required.

Somerset CCG Governance Committee Meetings 2015/16 – Attendance Record

✓ = Present
X = Apologies Given

(M) Committee member (A) In attendance	6 May 2015	29 Jul 2015	28 Oct 2015	10 Feb 2016
Dr Matthew Dolman (M) Chair	✓	X	✓	✓
Ann Anderson (M) Director of Clinical Commissioning Devt	X (CH)	X (CH)	X (CH)	✓
Lou Evans (M) Vice Chair and Non-Executive Director, Governance and Audit	✓	X	✓	✓
Dr Ed Ford (M) Chair of the Clinical Operations Group	✓	✓	✓	✓
Alison Henly (M) Chief Finance Officer and Director of Performance	✓	✓	X (HF)	X (AR)
Dr Sean O'Kelly (M) Non-Executive Director, Secondary Care Specialist Doctor	✓	X	X	X
Carolyn Moore (M) Non-Executive Director, Registered Nurse	✓	✓	✓	✓
Dr Iain Phillips (M) GP	✓	X	✓	X
David Slack (M) Managing Director/ Accountable Officer	✓	✓	✓	✓
Eilleen Tipper (M) Non-Executive Director, PPE	✓	✓	✓	✓
Lucy Watson (M) Director of Quality, Safety and Governance	✓	✓	✓	✓
Karen Taylor (A) Head of Patient Safety and Governance	✓	✓	✓	✓
Peter Osborne (A) Corporate Governance Manager	✓	✓	✓	X

Initials in brackets indicate deputising arrangements as follows:
CH – Claire Higdon for Ann Anderson
HF – Helena Fuller for Alison Henly
AR – Alison Rowswell for Alison Henly

Somerset CCG Remuneration Committee Meetings 2015/16 – Attendance Record

✓ = Present
X = Apologies Given

✓ = Present X = Apologies Given V = voting NV = non-voting	28 May 2015	17 Sept 2015	29 Oct 2015	30 Nov 2015	22 Feb 2016
Lou Evans (V) Remuneration Committee Chair	✓	✓	✓	✓	✓
Eilleen Tipper (V) Remuneration Committee Vice Chair	✓	✓	✓	✓	✓
David Bell (V) Chair of the Joint Committee (Primary Care)	✓	✓	✓	✓	✓
Carolyn Moore (V) Registered Nurse	✓	✓	✓	✓	✓
David Slack (NV) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	X	✓	✓	✓	X

Somerset Primary Care Joint Committee Meetings
2015/16 – Attendance Record

✓ = Present
X = Apologies Given

(M) Committee member (A) In attendance	Job Title	Committee Role (e.g. Executive, Lay, GP, etc)	15 Jun 15	24 Sept 15	10 Dec 15	24 Mar 16
David Bell (M)	Non-Executive Director, Chair of the Somerset Primary Care Joint Committee – Somerset CCG	Chair Non-Exec	✓	✓	✓	✓
Lou Evans (M)	Vice-Chair, Non-Executive Director, Governance and Audit – Somerset CCG	Vice Chair Non-Exec	✓	X	✓	✓
Ann Anderson (M)	Director of Clinical Commissioning Development– Somerset CCG	CCG	✓	✓	✓	✓
Alison Henly (M)	Chief Finance Officer and Director of Performance – Somerset CCG	CCG	✓	✓	✓ (DH)	✓
Carolyn Moore (M)	Non-Executive Director, Registered Nurse – Somerset CCG	Non-Exec	✓	X	X	✓
Linda Prosser (M)	Director, NHS England		✓	X	✓	✓
Eileen Tipper (M)	Non-Executive Director, PPE – Somerset CCG	Non-Exec	✓	✓	✓	✓
Lucy Watson (M)	Director of Quality, Safety and Governance – Somerset CCG	CCG	✓	X	✓	✓
Lesley Woakes (M)	Head of Primary Care, NHS England	NHS E	✓	✓	X	X
Louise Woolway (M)	Public Health Consultant, Somerset County Council – Somerset CCG	SCC	✓	✓	✓	✓
Dr Sean O'Kelly (M)	Non-Executive Director, Secondary Care Specialist Doctor, Somerset CCG	Non-Exec	X	X	X	✓
Dr Iain Phillips (M)	GP, Wincanton Health Centre and Somerton Surgery – Somerset CCG	GP	✓	X	✓	✓
Clive Coleman (M)	Finance, NHS England	NHS Executive	✓	X	✓	X
Dr Chris Campbell (M)	External GP Member	External GP	✓	✓	✓	✓
Martin Davidson (M)	PPG Chairs Representative, Somerset CCG	PPG Chair Rep	X	✓	✓	✓
Sue Roberts (M)	Chairman, Somerset Local Medical Committee	LMC	X	✓	✓	✓
Dr John Trepess (M)	GP Representative	GP	X	✓	X	✓
Tariq White (M)	Assistant Director of Transformation and Outcomes, NHS England	NHS E	X	✓	X	✓

(M) Committee member (A) In attendance	Job Title	Committee Role (e.g. Executive, Lay, GP, etc)	15 Jun 15	24 Sept 15	10 Dec 15	24 Mar 16
	South (South West)					
Anne Woodford (M)	Healthwatch Representative	Healthwatch	X	✓	X	✓
Tanya Whittle (A)	Associate Director: Community Services and Primary Care, Somerset CCG	CCG	✓	✓	✓	✓
Karen Taylor	Head of Patient Safety and Governance	CCG	✓	✓	✓	✓
Jo Perry	Independent Contractor		✓	✓	✓	✓
Cliff Puddy	Healthwatch Representative	Healthwatch	X	X	✓	X
Debbie Hillier	Deputy Chief Finance Officer/ Director of Performance	CCG	X	X	✓	X
Allison Nation	Head of IM&T Commissioning	CCG	X	X	✓	X

Initials in brackets indicate deputising arrangements as follows:
DH – Deborah Hillier for Alison Henly

REMUNERATION AND STAFF REPORT

3.106 This section of the report contains details of remuneration and pension entitlements for senior managers of the Trust in line with Section 234B and Schedule 7A of the Companies Act.

3.107 Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members. In defining this, the scope the CCG have used is to include members of the decision making groups within the CCG, which the CCG has defined as the Governing Body, excluding those members with no voting rights. Senior managers (excluding Lay Members) are generally employed on permanent contracts with a six month period of notice.

3.108 The CCG's Remuneration Committee is chaired by the Vice Chairman of the Governing Body. It is the Remuneration Committee that determines the reward packages of Executive Directors, whilst taking account of the Pay Framework for Very Senior Managers (VSM) published by the Department of Health.

3.109 Table 26 details the remuneration levels for all senior managers in the CCG.

Table 26: Salary Entitlements of Senior Managers

		Total 2015/16						Total 2014/15					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£'00	£'000	£'000	£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'000
David Slack	Managing Director/ Accountable Officer	120-125	0	0	0	5-7.5	125-130	120-125	0	0	0	0	120-125
Alison Henly	Chief Finance Officer and Director of Performance	100-105	44	0	0	27.5-30	135-140	50-55	18	0	0	10-12.5	65-70
Paul Goodwin	Director of Commissioning Reform	100-105	32	0	0	0	100-105	50-55	16	0	0	35-37.5	90-95
Lucy Watson	Director of Quality, Safety and Governance	100-105	0	0	0	17.5-20	115-120	95-100	0	0	0	22.5-25	120-125
Ann Anderson	Director of Clinical and Collaborative Commissioning	95-100	42	0	0	17.5-20	115-120	95-100	18	0	0	20-22.5	115-120
Matthew Dolman	Chair	90-95	0	0	0	22.5-25	115-120	90-95	0	0	0	7.5-10	100-105
Steven Foster	Director of System Transformation	15-20	0	0	0	2.5-5	20-25	0	0	0	0	0	0
Geoff Sharp	GP	35-40	0	0	0	0	35-40	35-40	0	0	0	20-22.5	55-60

Edward Ford	COG Chair	50-55	0	0	0	12.5-15	65-70	0	0	0	0	0	0
David Bell	Non Exec Director	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Iain Phillips	GP	35-40	0	0	0	0-2.5	40-45	35-40	0	0	0	302.5-305	340-345
Lou Evans	Lay Member (Vice-Chair)	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20
Eileen Tipper	Lay Member	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Sean O'Kelly	Specialist Doctor	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Carolyn Moore	Registered Nurse	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15

Notes:
Paul Goodwin returned from a secondment post with NHS England in May 2015. He returned to the post of Interim Director of Commissioning Reform. This post became his substantive post from December 2015.
Alison Henly was Interim Chief Finance Officer & Director of Performance & Acute Commissioning until February 2016 when she was appointed to the post of Chief Finance Officer & Director of Performance
Steven Foster was appointed to the post of Director of System Transformation in February 2016.
David Bell was appointed to the post of Non Executive Director in May 2015.
Sean O'Kelly was appointed to the post of Specialist Doctor in April 2015.
Expense payments relate to Lease Cars
No senior manager waived his/her remuneration.
No annual and long term performance related bonus payments were made to any senior managers in 2015/16.

Senior Manager Pension Benefits

3.110 The next table details the pension entitlements for each of the senior managers who received pensionable remuneration through the NHS pension scheme.

3.111 Senior managers are defined as those persons in senior positions having authority or responsibility for directing or controlling the major activities of the CCG. This means those who influence the decisions of the CCG as a whole, rather than the decisions of individual directorates or departments. Such persons will include advisory and lay members.

Table 27: Pensions Entitlement of Senior Managers

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 31 March 2016	Lump sum at pension age related to accrued pension at 31 March 2016	Cash equivalent transfer value at 1 April 2015	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2016	Employer's contribution to stakeholder pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Slack	Managing Director	0-2.5	2.5-5	35-40	115-120	748	27	784	0
Alison Henly	Chief Finance Officer and Director of Performance	0-2.5	0-2.5	30-35	85-90	436	24	465	0
Paul Goodwin	Director of Commissioning Reform	0-2.5	0-2.5	40-45	120-125	728	5	743	0
Lucy Watson	Director of Quality, Safety and Governance	0-2.5	2.5-5	30-35	90-95	671	40	718	0
Ann Anderson	Director of Clinical and Collaborative Commissioning	0-2.5	2.5-5	20-25	70-75	523	36	565	0
Steven Foster	Director of System Transformation	0-2.5	0	0-5	0	0	4	4	0
Matthew Dolman	Chair	0-2.5	0-2.5	10-15	30-35	168	20	189	0
Edward Ford	COG Chair	0-2.5	0	0-5	0	0	8	9	0
Geoff Sharp	GP	0	0	5-10	25-30	213	0	213	0
Iain Phillips	GP	0-2.5	0-2.5	15-20	55-60	350	9	363	0

Notes:

1. Lay members do not receive pensionable remuneration.
2. Pensionable contributions may include more than just those from CCG employment. Where a GP is under a contract of service with the CCG and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.

3.112 Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

3.113 The banded remuneration of the highest paid member of the Governing Body in Somerset CCG in the financial year 2015/16 was £122,500 (2014/15 £122,500). This was 3.51 times (2014/15 3.23 times) the median remuneration of the workforce, which was £34,876 (2014/15 £37,953).

3.114 In 2015/16, zero employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £11,808 to £122,500 (2014/15 £11,808 to £122,500).

3.115 There were three exit packages paid in 2015/16 with a total cost of £34,671.Details of these packages are within Note 4 of the Annual Accounts.

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

3.117 On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

3.118 Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

3.119 The average number of Clinical Commissioning Group staff employed by staff grouping can be found in Table 16 of the Summary Financial Statements.

3.120 The breakdown of the gender profile for the CCG as at the end of March 2016 is set out in Table 5 of the Statutory Responsibilities.

3.121 The Clinical Commissioning Group sickness absence in 2015/16 is set out in Table 17 of the Summary Financial Statements.

3.122 The Clinical Commissioning Group has applied the Health Problems and Disability in Employment policy in 2015/16

3.123 The Clinical Commissioning Group consultancy expenditure in 2015/16 was £1,232,000 (2014/15 £214,000), as per note 5 in the annual accounts.

3.124 The remuneration report and notes on pages 109-118 has been audited by Grant Thornton UK LLP, Somerset CCG's external auditors.

Table 28: Explanation of Key Terms used in Remuneration and Pension Reports

Term	Definition
Annual Performance Related Bonuses	Money or other assets received or receivable for the financial year as a result of achieving performance measures and targets for the period 1 April 2015 to 31 March 2016.
Cash Equivalent Transfer Value (CETV)	A 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. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
Employer's contribution to stakeholder pension	The amount that the Clinical Commissioning Group has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2016	The amount of lump sum pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2016
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.
Real increase in pensions at pension age	The amount by which the pension to which an individual will be entitled at pension age has increased during the year
Total accrued pension at pension age at 31 March 2016	The amount of annual pension to which an individual will be entitled on retirement at pension age as a result of their membership of the pension scheme to 31 March 2016

Remuneration of the Managing Director and Directors

3.125 The remuneration of the Managing Director and Directors within the CCG is the responsibility of the Remuneration Committee. The committee comprises four voting members and two non-voting members.

3.126 The membership and attendance at the Somerset CCG Remuneration Committee during 2015/16 is set out below (Table 29):

Table 29: Somerset CCG Remuneration Committee Meetings 2015/16 – Attendance Record

✓ = Present X = Apologies Given V = voting NV = non-voting	28 May 2015	17 Sept 2015	29 Oct 2015	30 Nov 2015	22 Feb 2016
Lou Evans (V) Remuneration Committee Chair	✓	✓	✓	✓	✓
Eilleen Tipper (V) Remuneration Committee Vice Chair	✓	✓	✓	✓	✓
David Bell (V) Chair of the Joint Committee (Primary Care)	✓	✓	✓	✓	✓
Carolyn Moore (V) Registered Nurse	✓	✓	✓	✓	✓
David Slack (NV) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	X	✓	✓	✓	X

3.127 No additional persons attended the Committee in order to provide legal advice on compliance with any relevant legislation.

Policy on Remuneration for Senior Managers during 2015/16 and future years

3.128 A benchmarking exercise was carried out across the South West to determine Senior Manager pay scales when the CCG became fully authorised in April 2013. The recommendations were implemented in determining Senior Manager and terms and conditions of employment. Further benchmarking exercises continue to take place with CCG's in the South West to ensure that pay scales remain competitive and in line with the NHS's current financial position.

3.129 Agenda for Change guidelines will be taken into consideration when assessing whether to award an inflationary increase to Directors.

Policy on Contracts

3.130 All Senior Managers are on permanent contracts with a six months' notice period in place.

Compensation and Terms of Office

3.131 NHS England have set restrictions on the payment of any compensation within the CCG. There have been no compensation terms agreed by NHS England.

Off-payroll Engagements

3.132 Off-payroll engagement as of 31 March 2016, for more than £220 per day and that last longer than six months (Table 30):

	Number
The number that have existed	14
Of which, the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	4
For between two and three years at the time of reporting	8
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	0

3.133 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.

	Number
Number of new engagements, or those that reached six months duration between 1 April 2015 and 31 March 2016	2
Number of the above which include contractual clauses giving the Somerset Clinical Commissioning Group the right to request assurance in relation to income tax and National Insurance obligations	2
Number for whom assurance has been requested	2
Of which, the number	
Assurance has been received	2
Assurance has not been received	0
Engagements terminated as a result of assurance not being received, or ended before assurance received	0

	Number
Number of off-payroll engagements of board members, and/ or, senior officials with significant financial responsibility, during the financial year	0
Number of individuals on payroll and off payroll that have been deemed “board members, and/ or, senior officials with significant financial responsibility”, during the financial year (this figure includes both on payroll and off-payroll engagements)	15

Signed:

David Slack

Accountable Officer

Somerset Clinical Commissioning Group

Date: 26 May 2016

Appendix One

Entity name:	NHS Somerset Clinical Commissioning Group
This year	2015-16
This year ended	31 March 2016
This year commencing:	01 April 2015

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	4.1.1	6,152	5,312
Operating Expenses	5	696,649	667,961
Other operating revenue	2	(3,621)	(4,727)
Net operating expenditure before interest		**699,180**	**668,546**
Investment Revenue	8	0	0
Other (gains)/losses	9	0	0
Finance costs	10	0	0
Net operating expenditure for the financial year		**699,180**	**668,546**
Net (gain)/loss on transfers by absorption	11	0	0
Total Net Expenditure for the year		**699,180**	**668,546**
Of which:			
Administration Income and Expenditure			
Employee benefits	4.1.1	5,717	5,169
Operating Expenses	5	6,475	8,346
Other operating revenue	2	(361)	(346)
Net administration costs before interest		**11,831**	**13,169**
Programme Income and Expenditure			
Employee benefits	4.1.1	435	143
Operating Expenses	5	690,174	659,615
Other operating revenue	2	(3,260)	(4,381)
Net programme expenditure before interest		**687,349**	**655,377**

Other Comprehensive Net Expenditure		2015-16 £000	2014-15 £000
Impairments and reversals	22	0	0
Net gain/(loss) on revaluation of property, plant & equipment		0	0
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net gain/(loss) on assets held for sale		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Share of (profit)/loss of associates and joint ventures		0	0
Reclassification Adjustments			
On disposal of available for sale financial assets		0	0
Total comprehensive net expenditure for the year		**699,180**	**668,546**

The notes on pages 5 to 33 form part of this statement

Statement of Financial Position as at 31 March 2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	13	394	181
Intangible assets	14	17	14
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		411	195
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	5,487	5,324
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	50	50
Total current assets		**5,539**	5,376
Non-current assets held for sale	21	0	0
Total current assets		**5,539**	5,376
Total assets		**5,950**	5,571
Current liabilities			
Trade and other payables	23	(29,997)	(29,875)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(910)	(522)
Total current liabilities		**(30,907)**	(30,397)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(24,957)**	(24,826)
Non-current liabilities			
Trade and other payables	23	0	0
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	0	0
Total non-current liabilities		**0**	0
Assets less Liabilities		**(24,957)**	(24,826)
Financed by Taxpayers' Equity			
General fund		(24,957)	(24,826)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(24,957)**	(24,826)

The notes on pages 5 to 33 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 26 May 2016 and signed on its behalf by:

David Slack
Accountable Officer
NHS Somerset Clinical Commissioning Group

Statement of Changes In Taxpayers Equity for the year ended 31 March 2016

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2015-16				
Balance at 1 April 2015	(24,826)	0	0	**(24,826)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2015	**(24,826)**	**0**	**0**	**(24,826)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating expenditure for the financial year	(699,180)			(699,180)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(699,180)**	**0**	**0**	**(699,180)**
Net funding	699,049	0	0	699,049
Balance at 31 March 2016	**(24,957)**	**0**	**0**	**(24,957)**

	General fund £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Changes in taxpayers' equity for 2014-15				
Balance at 1 April 2014	**(26,005)**	**0**	**0**	**(26,005)**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	**0**	**0**	**0**	**0**
Adjusted NHS Clinical Commissioning Group balance at 1 April 2014	**(26,005)**	**0**	**0**	**(26,005)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2014-15				
Net operating costs for the financial year	(668,546)			(668,546)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(668,546)**	**0**	**0**	**(668,546)**
Net funding	669,725	0	0	669,725
Balance at 31 March 2015	**(24,826)**	**0**	**0**	**(24,826)**

The notes on pages 5 to 33 form part of this statement

Statement of Cash Flows for the year ended 31 March 2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(699,180)	(668,546)
Depreciation and amortisation	5	37	5
Impairments and reversals	5	0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts		0	0
(Increase)/decrease in inventories		0	1
(Increase)/decrease in trade & other receivables	17	(164)	(2,237)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(130)	1,184
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(320)	(270)
Increase/(decrease) in provisions	30	708	341
Net Cash Inflow (Outflow) from Operating Activities		**(699,049)**	(669,522)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		0	(185)
(Payments) for intangible assets		0	(15)
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**0**	(200)
Net Cash Inflow (Outflow) before Financing		**(699,049)**	(669,722)
Cash Flows from Financing Activities			
Net Funding Received		699,049	669,725
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Net Cash Inflow (Outflow) from Financing Activities		**699,049**	669,725
Net Increase (Decrease) in Cash & Cash Equivalents	20	**0**	3
Cash & Cash Equivalents at the Beginning of the Financial Year		**50**	47
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**50**	50

The notes on pages 5 to 33 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 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis.

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

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

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention 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.

1.5 **Charitable Funds**

Somerset Clinical Commissioning Group does not have any Charitable Funds.

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.

The Clinical Commissioning Group has entered into a pooled budget with Somerset County Council. Under the arrangements, funds are pooled under Section75 of the NHS Act 2006 for integrated community equipment, learning disability, carers services and the Better Care Fund. memorandum note to the accounts provides details of the joint income and expenditure.

The pool is hosted by Somerset County Council. As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pool, which are then used to purchase healthcare services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreements.

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:

- valuation assumptions for property, plant and equipment – note 13
- Provisions recognised as at 31 March 2016 – note 30
- Income and Expenditure Accruals – notes 17 and 23

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.

Notes to the financial statements

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.

None of Somerset Clinical Commissioning Group's employees are members of the Local Government Superannuation Scheme, which is a defined benefits pension scheme.

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.

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 valuation.

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

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.

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.

Notes to the financial statements

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**

Somerset Clinical Commissioning Group does not have any donated assets.

1.15 **Government Grants**

Somerset Clinical Commissioning Group does not have any government grants.

1.16 **Non-current Assets Held For Sale**

Somerset Clinical Commissioning Group does not hold any non-current assets held for sale.

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**

The Clinical Commissioning Group does not have any lessor arrangements.

1.18 **Private Finance Initiative Transactions**

The Clinical Commissioning Group does not hold any PFI schemes.

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 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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.

Somerset Clinical Commissioning Group does not have any formal plans for restructuring.

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 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

Somerset Clinical Commissioning Group has not received any allowance in respect of carbon reduction or other similar schemes.

1.26 **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.

Notes to the financial statements

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.

1.27 **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.

1.27.4 **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.

In the year ended 31 March 2016 there were no assets carried at fair value.

1.28 **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.

In the year ended 31 March 2016, there were no financial liabilities held at fair value.

1.29 **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.

1.30 **Foreign Currencies**

The Clinical Commissioning Group's functional currency and presentational currency is sterling. The Clinical Commissioning Group does not have any exposure to foreign currencies.

1.31 **Third Party Assets**

The Clinical Commissioning Group does not have any third party assets.

1.32 **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).

1.33 **Subsidiaries**

The Clinical Commissioning Group does not have any subsidiaries.

1.34 **Associates**

The Clinical Commissioning Group does not have any associates.

1.35 **Joint Ventures**

The Clinical Commissioning Group does not have any joint ventures.

1.36 **Joint Operations**

The Clinical Commissioning Group does not have any joint operations.

1.37 **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.

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue for Contract with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

2 Other Operating Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	160	160	0	38
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	2,071	91	1,980	3,017
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	1,390	110	1,280	1,672
Total other operating revenue	**3,621**	**361**	**3,260**	**4,727**

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

3 Revenue

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
From rendering of services	3,621	361	3,260	4,727
From sale of goods	0	0	0	0
Total	**3,621**	**361**	**3,260**	**4,727**

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2015-16	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	5,117	4,790	327	4,733	4,558	175	384	232	152
Social security costs	416	410	6	395	389	6	21	21	0
Employer Contributions to NHS Pension scheme	584	576	8	554	546	8	30	30	0
Other pension costs	0	0	0	0	0	0	0	0	0
Other post-employment benefits	0	0	0	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0	0	0	0
Termination benefits	35	35	0	35	35	0	0	0	0
Gross employee benefits expenditure	**6,152**	**5,811**	**341**	**5,717**	**5,528**	**189**	**435**	**283**	**152**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,152**	**5,811**	**341**	**5,717**	**5,528**	**189**	**435**	**283**	**152**
Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**6,152**	**5,811**	**341**	**5,717**	**5,528**	**189**	**435**	**283**	**152**
Total - 2014-15	**5,312**	**5,217**	**95**	**5,169**	**5,108**	**61**	**143**	**109**	**34**

4.1.2 Recoveries in respect of employee benefits

2015-16	Total £000	Permanent Employees £000	Other £000	Total £000
Employee Benefits - Revenue				
Salaries and wages	0	0	0	0
Social security costs	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**0**	**0**	**0**	**0**

4.2 Average number of people employed

	2015-16 Total Number	2015-16 Permanently employed Number	2015-16 Other Number	2014-15 Total Number
Total	**105**	**101**	**4**	90
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

4.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	420	531
Total Staff Years	93	85
Average working Days Lost	**4.5**	**6.2**

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	0
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	0

Ill health retirement costs are met by the NHS Pension Scheme
The Clinical Commissioning Group has not agreed any early retirements in the year to 31 March 2016.

4.4 Exit packages agreed in the financial year

	2015-16 Compulsory redundancies		2015-16 Other agreed departures		2015-16 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	1	8,022	1	8,022
£10,001 to £25,000	0	0	2	26,650	2	26,650
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**3**	**34,672**	**3**	**34,672**

	2014-15 Compulsory redundancies		2014-15 Other agreed departures		2014-15 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	2,220	0	0	1	2,220
£10,001 to £25,000	0	0	0	0	0	0
£25,001 to £50,000	0	0	0	0	0	0
£50,001 to £100,000	0	0	0	0	0	0
£100,001 to £150,000	1	116,025	0	0	1	116,025
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**2**	**118,245**	**0**	**0**	**2**	**118,245**

	2015-16 Departures where special payments have been made		2014-15 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	0	0	0	0
£10,001 to £25,000	0	0	0	0
£25,001 to £50,000	0	0	0	0
£50,001 to £100,000	0	0	0	0
£100,001 to £150,000	0	0	0	0
£150,001 to £200,000	0	0	0	0
Over £200,001	0	0	0	0
Total	**0**	**0**	**0**	**0**

Analysis of Other Agreed Departures

	2015-16 Other agreed departures		2014-15 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	3	34,672	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	**3**	**34,672**	**0**	**0**

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

Other departure costs have been paid in accordance with the provisions of the Clinical Commissioning Group terms and contract of employment, PILON (payment in lieu of notice) clause.

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

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

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 to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2015-16, employers' contributions of £602,407 (2014-15: £546,333) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS

5. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	5,493	5,197	296	4,625
Executive governing body members	659	520	139	687
Total gross employee benefits	**6,152**	**5,717**	**435**	**5,312**
Other costs				
Services from other CCGs and NHS England	4,821	3,958	863	6,018
Services from foundation trusts	456,636	29	456,607	439,275
Services from other NHS trusts	23,337	0	23,337	38,465
Services from other NHS bodies	3	0	3	2
Purchase of healthcare from non-NHS bodies	119,485	0	119,485	94,629
Chair and Non Executive Members	281	281	0	338
Supplies and services – clinical	0	0	0	1
Supplies and services – general	1,222	461	761	778
Consultancy services	1,232	68	1,164	214
Establishment	631	324	307	821
Transport	19	13	6	12
Premises	766	765	1	1,433
Impairments and reversals of receivables	0	0	0	0
Inventories written down	0	0	0	0
Depreciation	34	34	0	4
Amortisation	3	3	0	0
Impairments and reversals of property, plant and equipment	0	0	0	0
Impairments and reversals of intangible assets	0	0	0	0
Impairments and reversals of financial assets				
· Assets carried at amortised cost	0	0	0	0
· Assets carried at cost	0	0	0	0
· Available for sale financial assets	0	0	0	0
Impairments and reversals of non-current assets held for sale	0	0	0	0
Impairments and reversals of investment properties	0	0	0	0
Audit fees	86	86	0	114
Other non statutory audit expenditure				
· Internal audit services	0	0	0	0
· Other services	0	0	0	0
General dental services and personal dental services	0	0	0	0
Prescribing costs	81,677	0	81,677	77,980
Pharmaceutical services	0	0	0	0
General ophthalmic services	470	0	470	0
GPMS/APMS and PCTMS	3,550	0	3,550	4,476
Other professional fees excl. audit	158	139	19	153
Grants to other public bodies	246	0	246	1,799
Clinical negligence	10	10	0	10
Research and development (excluding staff costs)	20	20	0	0
Education and training	137	76	61	149
Change in discount rate	0	0	0	0
Provisions	708	208	500	341
Funding to group bodies		0	0	0
CHC Risk Pool contributions	1,117	0	1,117	949
Other expenditure	0	0	0	0
Total other costs	**696,649**	**6,475**	**690,174**	**667,961**
Total operating expenses	**702,801**	**12,192**	**690,609**	**673,273**

6.1 Better Payment Practice Code

Measure of compliance	**2015-16 Number**	**2015-16 £000**	2014-15 **Number**	2014-15 **£000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	15,480	112,703	14,488	98,137
Total Non-NHS Trade Invoices paid within target	15,386	111,739	14,438	97,800
Percentage of Non-NHS Trade invoices paid within target	**99.39%**	**99.14%**	**99.65%**	**99.66%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,289	490,873	3,693	484,544
Total NHS Trade Invoices Paid within target	3,230	485,076	3,678	484,042
Percentage of NHS Trade Invoices paid within target	**98.21%**	**98.82%**	**99.59%**	**99.90%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2015-16 £000**	2014-15 £000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities
The Clinical Commissioning Group did not undertake any income generation activities in 2015/16.

8. Investment revenue
The Clinical Commissioning Group had no Investment Revenue as at 31 March 2016.

9. Other gains and losses
The Clinical Commissioning Group had no other gains and losses as at 31 March 2016.

10. Finance costs
The Clinical Commissioning Group had no Finance Costs as at 31 March 2016.

11. Net gain/(loss) on transfer by absorption
The Clinical Commissioning Group had not transferred any function(s) that gave rise to any recognised gain or loss as at 31 March 2016.

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Service Ltd. In 2015-16 the charge to the Clinical Commissioning Group picked up charges for properties that it occupied, as well as charges relating to under recovered costs for properties where the Clinical Commissioning Group was identified as the lead commissioner (£205k). This is reflected in Note 12.1.1.

While our arrangements with NHS Property Services Ltd fall within the definition of operating leases, the rental charge for future years has not yet been agreed. NHS Property Services are moving to a charge based system based on property rental values and the Clinical Commissioning Group is waiting for the schedule setting out the implications for Somerset. Consequently, this note does not include future minimum lease payments for these arrangements.

The Clinical Commissioning Group also has annual commitments under lease agreements for fleet vehicles and photocopiers. There are no contingent rentals or purchase options built within any of the current lease arrangements.

12.1.1 Payments recognised as an Expense

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense								
Minimum lease payments	0	699	11	**710**	0	1,357	10	**1,367**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**699**	**11**	**710**	**0**	**1,357**	**10**	**1,367**

12.1.2 Future minimum lease payments

	2015-16				2014-15			
	Land £000	Buildings £000	Other £000	Total £000	Land £000	Buildings £000	Other £000	Total £000
Payable:								
No later than one year	0	0	32	**32**	0	-	18	**18**
Between one and five years	0	0	36	**36**	0	-	24	**24**
After five years	0	0	0	**0**	0	-	-	**0**
Total	**0**	**0**	**68**	**68**	**0**	**0**	**42**	**42**

12.2 As lessor

The Clinical Commissioning Group had no leases let as at 31 March 2016.

13 Property, plant and equipment

2015-16	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 01 April 2015	0	0	0	0	0	0	262	30	292
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	165	82	247
Additions donated	0	0	0	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Cost/Valuation At 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**427**	**112**	**539**
Depreciation 01 April 2015	0	0	0	0	0	0	111	0	111
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Charged during the year	0	0	0	0	0	0	34	0	34
Transfer (to)/from other public sector body	0	0	0	0	0	0	0	0	0
Cumulative depreciation adjustment following revaluation	0	0	0	0	0	0	0	0	0
Depreciation at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**145**	**0**	**145**
Net Book Value at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**282**	**112**	**394**
Purchased	0	0	0	0	0	0	282	112	394
Donated	0	0	0	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**282**	**112**	**394**
Asset financing:									
Owned	0	0	0	0	0	0	282	112	394
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP Lift contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**282**	**112**	**394**

Revaluation Reserve Balance for Property, Plant & Equipment

The Clinical Commissioning Group had no Revaluation Reserve Balance as at 31 March 2016.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction
The Clinical Commissioning Group had no additions to assets under construction at 31 March 2016.

13.2 Donated assets
The Clinical Commissioning Group did not hold any donated assets at 31 March 2016.

13.3 Government granted assets
The Clinical Commissioning Group did not hold any government granted assets at 31 March 2016.

13.4 Property revaluation
The Clinical Commissioning Group had no property revaluation at 31 March 2016.

13.5 Compensation from third parties
The Clinical Commissioning Group had no compensation from third parties for assets impaired, lost or given up at 31 March 2016.

13.6 Write downs to recoverable amount
The Clinical Commissioning Group had no assets written down to recoverable amounts at 31 March 2016.

13.7 Temporarily idle assets
The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2016.

13.8 Cost or valuation of fully depreciated assets
The Clinical Commissioning Group had no fully depreciated assets with any value still in use as at 31 March 2016.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (years)
Buildings excluding dwellings	-	-
Dwellings	-	-
Plant & machinery	-	-
Transport equipment	-	-
Information technology	5	5
Furniture & fittings	7	10

14 Intangible non-current assets

2015-16	Computer Software: Purchased £000	Computer Software: Internally Generated £000	Licences & Trademarks £000	Patents £000	Development Expenditure (internally generated) £000	Total £000
Cost or valuation at 01 April 2015	15	0	0	0	0	15
Additions purchased	5	0	0	0	0	5
Additions internally generated	0	0	0	0	0	0
Additions donated	0	0	0	0	0	0
Additions government granted	0	0	0	0	0	0
Additions leased	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from other public sector body	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
Cost / Valuation At 31 March 2016	**20**	**0**	**0**	**0**	**0**	**20**
Amortisation 01 April 2015	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale and reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Upward revaluation gains	0	0	0	0	0	0
Impairments charged	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Charged during the year	3	0	0	0	0	3
Transfer (to) from other public sector body	0	0	0	0	0	0
Cumulative amortisation adjustment following revaluation	0	0	0	0	0	0
Amortisation At 31 March 2016	**3**	**0**	**0**	**0**	**0**	**3**
Net Book Value at 31 March 2016	**17**	**0**	**0**	**0**	**0**	**17**
Purchased	17	0	0	0	0	17
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2016	**17**	**0**	**0**	**0**	**0**	**17**

Revaluation Reserve Balance for intangible assets

The Clinical Commissioning Group had no Revaluation Reserve Balance as at 31 March 2016.

14 Intangible non-current assets cont'd

14.1 Donated assets
The Clinical Commissioning Group did not hold any donated intangible non-current assets at 31 March 2016.

14.2 Government granted assets
The Clinical Commissioning Group did not hold any intangible non-current government granted assets at 31 March 2016.

14.3 Revaluation
The Clinical Commissioning Group had no revaluation at 31 March 2016

14.4 Compensation from third parties
The Clinical Commissioning Group had no compensation from third parties for intangible non-current assets impaired, lost or given up at 31 March 2016.

14.5 Write downs to recoverable amount
The Clinical Commissioning Group had no intangible non-current assets written down to recoverable amounts at 31 March 2016.

14.6 Non-capitalised assets
The Clinical Commissioning Group had no significant intangible non-current assets not recognised as assets because they didn't meet the recognition criteria of IAS38 as at 31 March 2016.

14.7 Temporarily idle assets
The Clinical Commissioning Group had no temporarily idle assets as at 31 March 2016.

14.8 Cost or valuation of fully amortised assets
The Clinical Commissioning Group had no fully amortised assets still in use as at 31 March 2016.

14.9 Economic lives

	Minimum Life (years)	Maximum Life (years)
Computer software: purchased	5	5
Computer software: internally generated	-	-
Licences & trademarks	-	-
Patents	-	-
Development expenditure (internally generated)	-	-

15 Investment property
The Clinical Commissioning Group had no investment property as at 31 March 2016

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2015	0	0	2	0	0	0	2
Additions	0	0	0	0	0	0	0
Inventories recognised as an expense in the period	0	0	0	0	0	0	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to the statement of comprehensive net expenditure	0	0	0	0	0	0	0
Transfer (to) from -Goods for resale	0	0	0	0	0	0	0
At 31 March 2016	**0**	**0**	**2**	**0**	**0**	**0**	**2**

17 Trade and other receivables	**Current 2015-16 £000**	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
NHS receivables: Revenue	305	0	724	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	2,132	0	2,019	0
NHS accrued income	1,138	0	2	0
Non-NHS receivables: Revenue	766	0	1,672	0
Non-NHS receivables: Capital	0	0	0	0
Non-NHS prepayments	739	0	815	0
Non-NHS accrued income	329	0	50	0
Provision for the impairment of receivables	0	0	0	0
VAT	78	0	42	0
Private finance initiative and other public private partnership arrangement prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	0	0	0	0
Total Trade & other receivables	**5,487**	**0**	**5,324**	**0**
Total current and non current	**5,487**		**5,324**	
Included above:				
Prepaid pensions contributions	0		0	

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

17.1 Receivables past their due date but not impaired	**2015-16 £000**	2014-15 £000
By up to three months	448	309
By three to six months	38	0
By more than six months	139	1,069
Total	**625**	**1,378**

£307,924 of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables	**2015-16 £000**	2014-15 £000
Balance at 01 April 2015	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2016	**0**	**0**

	2015-16 £000	2014-15 £000
Receivables are provided against at the following rates:		
NHS debt	0	0

18 Other financial assets
The Clinical Commissioning Group had no other financial assets as at 31 March 2016.

19 Other current assets
The Clinical Commissioning Group had no other current assets as at 31 March 2016.

20 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01 April 2015	50	47
Net change in year	0	3
Balance at 31 March 2016	**50**	**50**
Made up of:		
Cash with the Government Banking Service	50	50
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**50**	**50**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2016	**50**	**50**
Patients' money held by the Clinical Commissioning Group, not included above	0	0

21 Non-current assets held for sale
The Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2016.

22 Analysis of impairments and reversals
The Clinical Commissioning Group made no impairments in 2015-16

23 Trade and other payables	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
Interest payable	0	0	0	0
NHS payables: revenue	1,880	0	5,858	0
NHS payables: capital	0	0	0	0
NHS accruals	1,204	0	1,984	0
NHS deferred income	0	0	0	0
Non-NHS payables: revenue	6,546	0	3,353	0
Non-NHS payables: capital	252	0	0	0
Non-NHS accruals	19,100	0	18,066	0
Non-NHS deferred income	0	0	0	0
Social security costs	76	0	55	0
VAT	0	0	0	0
Tax	82	0	60	0
Payments received on account	0	0	0	0
Other payables	857	0	499	0
Total Trade & Other Payables	**29,997**	**0**	**29,875**	**0**
Total current and non-current	**29,997**		**29,875**	

Other payables include £105,150 outstanding pension contributions at 31 March 2016.

24 Other financial liabilities
The Clinical Commissioning Group had no other financial liabilities as at 31 March 2016.

25 Other liabilities
The Clinical Commissioning Group had no other liabilities as at 31 March 2016.

26 Borrowings
The Clinical Commissioning Group had no borrowings as at 31 March 2016.

27 Private finance initiative, LIFT and other service concession arrangements
The Clinical Commissioning Group does not have any private finance initiative, LIFT or other service concession arrangements that were included or excluded from the Statement of Financial Position as at 31 March 2016.

28 Finance lease obligations
The Clinical Commissioning Group had no finance lease obligations as at 31 March 2016.

29 Finance lease receivables
The Clinical Commissioning Group had no finance lease receivables as at 31 March 2016.

29.1 Finance leases as lessor
The Clinical Commissioning Group had no unguaranteed residual value accruing as at 31 March 2016.
The Clinical Commissioning Group had no accumulated allowance for uncollectible lease receivables as at 31 March 2016.

30 Provisions

	Current 2015-16 £000	**Non-current 2015-16 £000**	Current 2014-15 £000	Non-current 2014-15 £000
Pensions relating to former directors	0	0	0	0
Pensions relating to other staff	0	0	0	0
Restructuring	0	0	0	0
Redundancy	0	0	0	0
Agenda for change	0	0	0	0
Equal pay	0	0	0	0
Legal claims	0	0	0	0
Continuing care	702	0	372	0
Other	208	0	150	0
Total	**910**	**0**	**522**	**0**
Total current and non-current	**910**		**522**	

	Pensions Relating to Former Directors £000s	**Pensions Relating to Other Staff £000s**	**Restructuring £000s**	**Redundancy £000s**	**Agenda for Change £000s**	**Equal Pay £000s**	**Legal Claims £000s**	**Continuing Care £000s**	**Other £000s**	**Total £000s**
Balance at 01 April 2015	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**372**	**150**	**522**
Arising during the year	0	0	0	0	0	0	0	692	208	900
Utilised during the year	0	0	0	0	0	0	0	(170)	(150)	(320)
Reversed unused	0	0	0	0	0	0	0	(192)	0	(192)
Unwinding of discount	0	0	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**702**	**208**	**910**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	702	208	910
Between one and five years	0	0	0	0	0	0	0	0	0	0
After five years	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**702**	**208**	**910**

The "Continuing Care" provision is an assessment of the continuing care cases which are currently being reviewed by the Clinical Commissioning Group's panel. This has been based on the best professional judgement in line with IAS37. All of the cases awaiting panel have been provided for and the calculation has been based on estimated cost and the probability of success, where the probability factor applied is based on success rates in the current financial year or professional judgement. A contingent liability in respect of this provision is shown in note 31.

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 Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2016 is £225k

The "Other" provision is a provision made by the Clinical Commissioning Group in relation to a review currently being undertaken by Her Majesty Revenue and Customs. The Clinical Commissioning Group is cooperating fully with their investigations

31 Contingencies

	2015-16 £000	2014-15 £000
Contingent liabilities		
Equal Pay	0	0
NHS Litigation Authority Legal Claims	0	0
Employment Tribunal	0	0
NHSLA employee liability claim	0	0
Redundancy	0	0
Continuing Healthcare	92	56
Litigation	0	1
Her Majesty's Revenue and Customs	42	0
Net value of contingent liabilities	**134**	**57**
Contingent assets		
Amounts payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2016.

32.2 Other financial commitments

The Clinical Commissioning Group had no non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) as at the 31 March 2016.

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the Clinical Commissioning Group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group and it's internal auditors.

33.1.1 Currency risk

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

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the Clinical Commissioning Group's revenue comes from parliamentary funding, The Clinical Commissioning Group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note 17.

33.1.4 Liquidity risk

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

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss' 2015-16 £000	**Loans and Receivables 2015-16 £000**	**Available for Sale 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	1,443	0	1,443
· Non-NHS	0	1,095	0	1,095
Cash at bank and in hand	0	50	0	50
Other financial assets	0	0	0	0
Total at 31 March 2016	**0**	**2,588**	**0**	**2,588**

	At 'fair value through profit and loss' 2014-15 £000	Loans and Receivables 2014-15 £000	Available for Sale 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	724	0	724
· Non-NHS	0	1,672	0	1,672
Cash at bank and in hand	0	50	0	50
Other financial assets	0	0	0	0
Total at 31 March 2015	**0**	**2,446**	**0**	**2,446**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2015-16 £000	**Other 2015-16 £000**	**Total 2015-16 £000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,084	3,084
· Non-NHS	0	26,755	26,755
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2016	**0**	**29,839**	**29,839**

	At 'fair value through profit and loss' 2014-15 £000	Other 2014-15 £000	Total 2014-15 £000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	7,842	7,842
· Non-NHS	0	21,919	21,919
Private finance initiative, LIFT and finance lease obligations	0	0	0
Other borrowings	0	0	0
Other financial liabilities	0	0	0
Total at 31 March 2015	**0**	**29,761**	**29,761**

34 Operating segments

	Gross expenditure	Income	Net expenditure	Total assets	Total liabilities	Net assets
	£'000	£'000	£'000	£'000	£'000	£'000
NHS Somerset CCG	702,801	(3,621)	**699,180**	5,950	(30,907)	**(24,957)**
Total	**702,801**	**(3,621)**	**699,180**	**5,950**	**(30,907)**	**(24,957)**
2014-15	673,273	(4,727)	668,546	5,571	(30,397)	(24,826)

Reconciliation between Operating Segments and SoCNE

	31-Mar-16 £'000
Total net expenditure reported for operating segments	699,180
Total net expenditure per the Statement of Comprehensive Net Expenditure	**699,180**

Reconciliation between Operating Segments and SoFP

	31-Mar-16 £'000
Total assets reported for operating segments	5,950
Total assets per Statement of Financial Position	**5,950**

	31-Mar-16 £'000
Total liabilities reported for operating segments	(30,907)
Total liabilities per Statement of Financial Position	**(30,907)**

35 Pooled budgets

The Clinical Commissioning Group had entered into a pooled budget with Somerset County Council. The pool is hosted by Somerset County Council.

Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Learning Disability Service, the Integrated Community Equipment Service and the Carers Support Service.

2015/2016 POOLED BUDGET MEMORANDUM OF ACCOUNTS

Integrated Community Equipment Service	2014/15 £	2015/16 £
Income from:		
Adults & Health Services	1,144,157	1,116,079
Children & Learning Services	354,835	320,759
Clinical Commissioning Group (Inclu. CHC Inc) 1	1,380,066	1,455,669
Section 256	1,094,446	1,200,000
Other Income	3,288	
Total funding	3,976,792	4,092,507
Expenditure:		
Equipment, Delivery, Minor Works [2]	3,805,538	4,243,488
Management and Administration	83,709	93,209
Total Expenditure	3,889,247	4,336,697
Variation	(87,545)	244,190

Notes:

[1] Includes £404,716 CHC Income.

[2] Includes £326,639 Creditor Provision. No Debtor Provision was made.

[3] 50% of the overspend has been invoiced to CCG (£122,095).

Carers Pooled Budget	2014/15 £	2015/16 £
Income from:		
Adults & Health Services	203,500	203,500
Care Act Funding	0	47,630
Clinical Commissioning Group	203,500	204,000
Health & Wellbeing Grant	0	1,250
Funding Carried Forward	63,106	38,909
Total Funding	470,106	495,289
Expenditure:		
Universal Carers Support Service	407,000	407,500
Carers Support Worker Salary/Running Costs	24,197	29,138
Earmarked Reserve	38,909	58,651
Total Expenditure	470,106	495,289
Variation	0	0

Notes:

[1] £19,742 has been put into the earmarked reserve in 15/16. The reserve has a balance of £58,651 in the reserve.

[2] No Creditor or Debtor Provision has been made.

Learning Disabilities Services	2014/15 £	2015/16 £
Income from:		
Adults & Health Services	46,840,000	49,370,400
Pensions Equalisation Reserve	383,000	383,000
Clinical Commissioning Group	16,811,613	18,248,577
Section 256	1,455,825	550,000
Income From Charges & Grant Income	6,330,515	6,860,616
Total Funding	71,820,953	75,412,593
Expenditure:		
Purchasing (Independent Sector)	38,222,907	45,528,788
Residential Services	10,040,730	9,899,473
Supported Housing	15,687,934	13,111,017
Day Services	6,138,247	7,162,817
Community Teams	3,196,072	1,278,654
Mental Capacity	570,637	250,162
Total Expenditure	73,856,527	77,230,911
Variation	2,035,574	1,818,318

Notes:

[1] Creditor Provision of £2,354,767.10 has been made.

[2] Debtor Provision of -£512,864.87 has been made including -£454,579.89 for CCG contribution to overspend.

[3] PIA Provision of -£279,757.05 has been made.

[4] No RIA Provision has been made.

[5] No Debt Impairment has been made.

Certificate of Group Manager - Finance, Community Services Directorate

I certify that the above pooled budget memorandum of accounts accurately discloses the income received and expenditure incurred in accordance with the partnership agreement, as amended by any subsequent agreed variations, entered into under section 75 of the National Health Service Act 2006.

……..

Martin Young
Finance Group Manager - Community Directorate
Somerset County Council

35 Pooled Budgets cont'd

The Better Care Fund in Somerset

In 2015/16 the Better Care Fund was established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that NHS Somerset Clinical Commissioning Group and Somerset County Council establish a pooled fund for this purpose, which was achieved in 2015/16 through a signed agreement under Section 75 of the National Health Service Act 2006.

Under this Section 75 agreement there are three funds totalling £41.343m and hosted by whichever body undertook the contracting arrangements. These funds support the four schemes supported by the Better Care Fund namely Reablement, Person-centred care, Avoiding Admissions for Older People and Housing Adaptions. The Somerset Better Care Fund arrangement is shown diagrammatically and described below: -

Actual Expenditure 2015/16	Fund 1	Fund 2	Fund 3	BCF Total
	£'000	£'000	£'000	£'000
Scheme A – Reablement & other social care schemes	2,712	11,447*		14,159
Scheme B – Person-centred care	17,617	203	2,780	20,600
Scheme C - Frail Older Persons Assessment Service (FOPAS)	3,088			3,088
Scheme D – Housing Adaptions			2,105	2,105
Capital Expenditure (Care Act)			1,391	1,391
Total per Fund	**23,417**	**11,650**	**6,276**	**41,343**

*** Somerset County Council incurred expenditure of £11.248m against this fund during 2015/16.**

Fund 1 is hosted by the Clinical Commissioning Group and totals £23.417m. The fund includes contributions from the CCG only, which have been paid to providers contracted to support the Reablement, Person-centred care and Avoiding Admissions for Older People schemes. The CCG paid Somerset Partnership NHS Foundation Trust £9.272m Taunton & Somerset NHS Foundation Trust £8.276m and Yeovil District Hospital NHS Foundation Trust £5.869m.The CCG controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 agreement.

In terms of accounting entries all expenditure incurred as part of this fund is accounted for by the CCG.

Fund 2 is hosted by Somerset County Council and totals £11.650m. This fund includes a small amount of funding, £203,500, which is the CCGs contribution to the Carers Pooled budget.

The remaining fund is a contribution from the CCG paid to Somerset County Council for them to contract to support the Reablement scheme. The County Council controls this fund and wholly owns any risk relating to this fund as per the Section 75 agreement, therefore under IFRS 11 this fund is not classed as a joint arrangement.

In terms of accounting entries the contribution incurred as part of this fund is accounted for within the CCG accounts, with the County Council accounting for this CCG contribution as income and the associated expenditure with providers for this fund.

Fund 3 is hosted by Somerset County Council and totals £6.276m. The fund includes contributions from the County Council only, which have been paid to providers contracted to support the Person-centred care and Housing Adaptions schemes. The County Council controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 agreement.

In terms of accounting entries all expenditure incurred as part of this fund is accounted for by the County Council.

36 NHS Lift investments

The Clinical Commissioning Group had no NHS LIFT investments as at 31 March 2016.

37 Related party transactions

Details of related party transactions with individuals are as follows:

31 March 2016	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Chair Dr Matthew Dolman is a GP Partner at Axbridge and Wedmore Medical Practice, is a Member of North Sedgemoor GP Federation, is a Member of North Sedgemoor GP Commissioning Locality, is one of the Clinical Commissioning Group's nominated members of the Somerset County Council's Health and Wellbeing Board, his wife is an extended scope physiotherapist at Somerset Partnership NHS Foundation Trust and has an interest in Somerset Primary Healthcare Ltd.				
Axbridge & Wedmore Medical Practice	88	0	0	0
North Sedgemoor GP Federation	72	0	0	0
North Sedgemoor GP Commissioning Locality - **added 01/10/15**	6	0	0	0
Somerset County Council	45,640	1,453	3,094	285
Somerset Partnership NHSFT	128,909	0	465	26
Somerset Primary Healthcare Ltd	125	0	2	0
Vice Chair Lou Evans is a director at ARC Homes, is a director at Martin Brooks Associates Limited, his wife is employed as an Occupational Therapist at Somerset Partnership NHS Foundation Trust, is a member of the Avon and Somerset main committee for selection of a Justice of the Peace and is the Clinical Commissioning Group's nominated governor for Yeovil District Hospital NHS Foundation Trust.				
Somerset Partnership NHSFT	128,909	0	465	26
Yeovil District Hospital NHSFT	82,325	1	95	582
ARC Homes	0	0	0	0
Martin Brooks Associates Ltd	0	0	0	0
Justice of the Peace Committee	0	0	0	0
Managing Director/ Accountable Officer David Slack is one of the Clinical Commissioning Group's nominated members of the Somerset County Council's Health and Wellbeing Board, his daughter is employed as a support worker with the Learning Disability Service at Somerset County Council.				
Somerset County Council - **updated 25/02/16**	45,640	1,453	3,094	285
Chair of the Clinical Operations Group Dr Ed Ford - **appointed 01/05/15** is a GP Partner at Irnham Lodge Surgery, is a Member of West Somerset GP Federation, is a Member of West Somerset GP Commissioning Locality, is a First Responder for Somerset Accident Voluntary Emergency Service, is a Hospital Practitioner at Minehead Minor Injury Unit (under contract to Somerset Partnership NHS Foundation Trust), he works shifts in the 999 GP Project for South Western Ambulance Service NHS Foundation Trust, his wife works as a Nurse Practitioner at Yeovil Walk-In Centre (formerly at Irnham Lodge Surgery) and she is also Lead Nurse for the Age UK 'Living Better Together' project in West Somerset and he has an interest in Somerset Primary Healthcare Limited.				
Irnham Lodge Surgery	93	0	0	0
West Somerset GP Federation - **added 17/09/15**	22	0	0	0
West Somerset GP Commissioning Locality - **added 01/10/15**	9	0	0	0
Somerset Accident Voluntary Emergency Service	0	0	0	0
Somerset Partnership NHSFT	128,909	0	465	26
South Western Ambulance Service NHS FT	21,620	0	52	0
Yeovil Walk-In Centre - Yeovil Health Centre - **added 17/09/15**	13	0	0	0
Age UK - **added 28/01/16**	0	0	0	0
Somerset Primary Healthcare Ltd	125	0	2	0
GP Dr Geoff Sharp is a GP Partner at The Park Medical Partnership, PMS Practice which also is a provider to Shepton Mallet Community Hospital under contract from Somerset Partnership NHS Foundation Trust, is a Member of Central Mendip GP Federation, is the Chair of Central Mendip GP Commissioning Locality, provides out of hours services to Somerset Doctors Urgent Care (formerly to South Western Ambulance Service NHS Foundation Trust) and has an interest in Somerset Primary Healthcare Limited.				
Park Medical Partnership, PMS Practice	97	0	0	0
Central Mendip GP Federation	0	0	0	0
Central Mendip GP Commissioning Locality - **added 01/10/15**	0	0	0	0
Somerset Partnership NHSFT	128,909	0	465	26
South Western Ambulance Service NHSFT - **withdrew 30/06/15**	21,620	0	52	0
Somerset Doctors Urgent Care (Vocare Group) - **added 01/07/15**	5,165	0	0	35
Somerset Primary Healthcare Ltd	125	0	2	0
GP Dr Iain Phillips is a GP Partner at Wincanton Health Centre, is a Member of South Somerset GP Federation, is a Member of South Somerset Commissioning Locality, is a Director and Shareholder of Pathways Health and Social Care Alliance Ltd, is a Director of Wincanton Healthcare Ltd, of which Wincanton Health Centre is a provider of medical services to Wincanton Community Hospital, which is part of Somerset Partnership NHS Foundation Trust, is a Partner at Somerton Surgery and has an interest in Somerset Primary Healthcare Limited.				
Wincanton Health Centre	126	0	0	1
South Somerset GP Federation	44	0	0	0
South Somerset Commissioning Locality - **added 01/10/15**	18	0	0	0
Pathways Health and Social Care Alliance Ltd	3	0	0	0
Wincanton Healthcare Ltd	0	0	0	0
Somerset Partnership NHSFT	128,909	0	465	26
Somerton Surgery	40	0	0	0
Somerset Primary Healthcare Ltd	125	0	2	0
Specialist Doctor Dr Sean O'Kelly - **appointed 30/04/15** is the Medical Director at University Hospitals Bristol NHS Foundation Trust, is a special advisor for the Care Quality Commission, is an expert advisor on clinical governance and quality improvement for the World Health Organisation, his wife is a salaried GP at Lechlade Medical Centre Gloucestershire.				
University Hospitals Bristol NHSFT	8,097	0	84	16
Care Quality Commission	0	1	0	0
World Health Organisation	0	0	0	0
Lechlade Medical Centre	0	0	0	0
Chief Finance Officer and Director of Performance Alison Henly has no interests to declare.				
Registered Nurse Carolyn Moore is owner and director of Be More Consultancy, is the Clinical Commissioning Group's nominated Governor of Taunton and Somerset NHS Foundation Trust (formerly for Somerset Partnership NHS Foundation Trust) and is a staff nurse, on the nurse bank, at Yeovil District Hospital NHS Foundation Trust.				
Be More Consultancy	0	0	0	0
Somerset Partnership NHSFT - **withdrew 22/10/15**	128,909	0	465	26
Taunton & Somerset NHSFT - **added 22/10/15**	174,863	68	0	1,741

31 March 2016	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Yeovil District Hospital NHSFT - **withdrew 19/11/15**	82,325	1	95	582
Director of Public Health Trudi Grant is Director of Public Health at Somerset County Council, a member of Somerset County Council's Health and Wellbeing Board, an Observer of the Board of Somerset Activity and Sports Partnership and her sister is employed by Care Focus.				
Somerset County Council	45,640	1,453	3,094	285
Somerset Activity and Sports Partnership - **added 17/09/15**	0	0	0	0
Care Focus - **added 17/09/15**	13	0	0	0
Lay Member Eileen Tipper is a director of the Children & Young People's Partnership In Somerset (CHYPPS), is a member of Somerset Children's Trust Board at Somerset County Council and a member of the Policy and People Scrutiny Committee at Somerset County Council.				
Children & Young People's Partnership In Somerset	0	0	0	0
Somerset County Council	45,640	1,453	3,094	285
Lay Member and Chair of the Joint Committee for Commissioning Primary Care David Bell - **appointed 28/05/15** is Principal at LGPS Resources-Planning and Highway Consultancy, a Planning Agent for Yeovil Town Football Club and Yeovil Town Holdings Limited Planning Applications.				
LGPS Resources - **added 16/07/15**	0	0	0	0
Yeovil Town Football Club - **added 16/07/15**	0	0	0	0
Yeovil Town Holdings Limited - **added 16/07/15**	0	0	0	0
Director of Clinical and Collaborative Commissioning Ann Anderson has no interests to declare.				
Director of Commissioning Reform Paul Goodwin has a daughter in law who is an employee of PricewaterhouseCoopers LLP (formerly at Mazars LLP (Deloitte LLP) - **returned from Secondment on 05/5/15**.				
Deloitte LLP - **withdrew 17/09/15**	0	0	0	0
PricewaterhouseCoopers LLP - **added 17/09/15**	548	0	290	0
Lay Observer Peter Rowe is the Chair of West Somerset Healthcare Patient Participation Group and the Chair of the County Patient Participation Group Chairs' Group.				
West Somerset Healthcare - **withdrew 28/05/15**	4	0	0	0
County PPG Chairs' Group	0	0	0	0
Local Medical Committee Observer Dr Harry Yoxall is the Medical Secretary of the Somerset Local Medical Committee, is a Trustee of St Margaret's Somerset Hospice and his wife is a freelance locum GP.				
Somerset LMC	44	32	0	1
St Margaret's Somerset Hospice - **withdrew 31/03/16**	2,212	293	155	0
Director of Quality, Safety and Governance Lucy Watson is a Specialist Professional Advisor for the Care Quality Commission.				
Care Quality Commission	0	1	0	0
Director of Systems Transformation Steven Foster - **appointed 01/02/16** is a joint post with Somerset County Council.				
Somerset County Council	45,640	1,453	3,094	285

Note

The related parties have been identified through the register of members' interests, but have been amended to include related parties only. Under IAS 24 a person is a related party if they: -

(i) have control or joint control over the reporting entity;

(ii) have significant influence over the reporting entity; or

(iii) are a member of the key management personnel

All relevant organisations have then been checked for the level of business activity on both the purchase and sales ledgers i.e. a governor of Yeovil District Hospital NHS Foundation Trust will have the total of all the annual transactions along with the year end debtor and creditor values noted against their name.

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. For example:

31 March 2016	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
NHS England	1,210	410	13	493
South West Commissioning Support Unit	4,716	0	95	0
NHS FOUNDATION TRUSTS				
Dorset County Hospital NHS Foundation Trust	2,229	0	0	20
Great Western Hospital NHS Foundation Trust	134	0	21	0
Royal Brompton & Harefield NHS Foundation Trust	458	0	64	0
Royal Devon and Exeter NHS Foundation Trust	5,117	0	0	126
Royal United Hospital Bath NHS Foundation Trust - FT status 01/11/14	29,471	0	485	0
Salisbury NHS Foundation Trust	616	0	7	0
Somerset Partnership NHS Foundation Trust	128,909	0	465	26
South Western Ambulance Service NHS Foundation Trust	21,620	0	52	0
Taunton and Somerset NHS Foundation Trust	174,863	68	0	1,741
University Hospitals Bristol NHS Foundation Trust	8,097	0	84	16
Yeovil District Hospital NHS Foundation Trust	82,325	1	95	582
NHS TRUSTS				
North Bristol NHS Trust	6,574	0	0	544
Northern Devon Healthcare NHS Trust	510	0	6	0
Weston Area Health NHS Trust	14,143	0	20	0

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Somerset County Council, NHS Property Services Limited, National Insurance Fund, NHS Pension Scheme and Her Majesty Revenue and Customs.

38 Events after the end of the reporting period
There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group or consolidated group.

39 Losses and special payments
The Clinical Commissioning Group had no losses and special payments cases during 2015-16.

40 Third party assets
The Clinical Commissioning Group held no third party assets as at 31 March 2016.

41 Financial performance targets

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

The Clinical Commissioning Group performance against those duties was as follows:

	2015-16 Target £'000	**2015-16 Performance £'000**	2014-15 Target £'000	2014-15 Performance £'000
Expenditure not to exceed income	6,484	6,484	7,475	7,475
Capital resource use does not exceed the amount specified in Directions	252	252	200	200
Revenue resource use does not exceed the amount specified in Directions	705,664	699,180	676,021	668,546
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	252	252	200	200
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	692,635	687,349	661,612	655,377
Revenue administration resource use does not exceed the amount specified in Directions	13,029	11,831	14,409	13,169

The revenue administration resource is £11,831,000 from the running cost allowance and £1,198,000 Quality Premium allocation. The Clinical Commissioning Group took the decision to spend all the Quality Premium allocation on Programme activities.

42 Impact of IFRS
Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2015-16 financial year

43 Analysis of charitable reserves

	2015-16 £'000	2014-15 £'000
Unrestricted funds	0	0
Restricted funds	0	0
Endowment funds	0	0
Total	**0**	**0**

Appendix Two

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS SOMERSET CLINICAL COMMISSIONING GROUP

We have audited the financial statements of NHS Somerset CCG for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRS) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 Frem) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

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

- the table of salaries and allowances of senior managers and related narrative notes on page 110 and 111
- the table of pension benefits of senior managers and related narrative notes on page 112
- the exit packages narrative notes on page 113.
- the analysis of staff numbers narrative notes on page 113; and
- the narrative note of pay multiples on page 113.

This report is made solely to the members of the Governing Body of NHS Somerset CCG as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Act (the "Code of Audit Practice").

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Somerset CCGas at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRS as adopted by the European Union, as interpreted and adapted by the 2015/16 Frem as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRS as adopted by the European Union, as interpreted and adapted by the 2015/16 Frem as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the CCG under section 24 of the Act; or
- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Somerset CCG in accordance with the requirements of the Act and the Code of Audit Practice.

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

Grant Thornton UK LLP Hartwell House 55-61 Victoria Street Bristol BS1 6FT

26 May 2016