NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2017/18

24 May 2018

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SOMERSET CCG ANNUAL REPORT 2017/18

Contents

INTRODUCTION

Somerset Clinical Commissioning Group (CCG) has experienced a range of challenges which have contributed to a difficult year for the health system as a whole. This Annual report sets out the achievements and challenges that the CCG and its GP members have experienced in 2017/18.

We have produced the Annual Report to highlight what we have achieved in 2017/18 and what we will now achieve in 2018/19, recognising that this is part of a three year plan to recover the overall system financial position by 2020/21.

In July 2017 Somerset CCG was issued with a performance rating by NHS England as 'inadequate' and was place in a reframed CCG special measures regime. Key areas to the failure of the CCG were:

- Insufficient progress was made against leading the financial recovery for the CCG and for the Somerset health system.
- Although we had made good progress in many of the better care domains rising patient demand and failure of some key performance measures remained.
- System leadership was ineffective and collaborative system working did not support or improve our underlying deficit and performance issues.

The Somerset CCG Governing Body took action and have plans in place to improve the financial position in Somerset whilst ensuring that quality and safety are central to decision making ensuring our patients and public receive high quality and equitable access to health services in Somerset.

I was appointed as the new Chief Officer in August 2017 and have led and supported our internal senior management and GP clinical leadership to improve and ensure that clinical commissioning and decision making is central. We are updating our governance processes and ensuring that there is robust assurance and accountability within the CCG which includes ensuring that requirements of the Improvement and Assessment Framework for CCGs is key to our decision making.

We have embarked on developing a health and care strategy for Somerset. This strategy is being developing in partnership with our colleagues in Somerset County Council thus ensuring a more integrated approach across health and social care. It will be based on clinical need and address inequalities in health whilst ensuring that it is financially affordable for Somerset.

We will ensure that our patients and public are involved with the co-design of our services for the future.

Although finances have been difficult the CCG has completed its annual accounts and subject to audit, the CCG has achieved its control total. However, the Somerset system has recorded a deficit of £19.4 million in 2017/18 of which £0.5m is reflected in the CCG financial position. We have however committed, with our Somerset system partners, to undertake joint planning initially for the period 2018/19 to 2020/21, developing joint plans to bring the system back into financial balance within

a three year period. This will include a system wide turnaround approach. This turnaround approach will support improving the financial position in 2018/19 and include focussed effort around demand management opportunities and cost reductions across the system.

We are committed to working in a more integrated way as a health and care system across Somerset with all system partners, stakeholders and our patients and the public.

The success and strength of Somerset's health and social care system is the willingness of health professionals, NHS staff and patient representatives to work in collaboration and find better ways to improve patient care and support for carers.

I would like to extend my thanks to everyone for their hard work and support this year and look forward to working with you all in the coming year.

Nick Robinson
Accountable Officer
Somerset Clinical Commissioning Group

24 May 2018

1 PERFORMANCE REPORT

Nick Robinson

Accountable Officer

24 May 2018

Performance Overview

Review of CCG Business for 2017/18

The Performance Overview section of the CCG's Annual Report provides an overarching review of the key achievements we have made to deliver our priorities in 2017/18 and also highlight what we aim to achieve in 2018/19, recognising that this is part of a three year plan to recover the overall system financial position by 2020/21.

Profile of Somerset

1.1 Somerset CCG covers a largely rural county of approximately 560,000 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. Somerset is the 12th largest county in England and West Somerset (containing much of Exmoor) is the 6th least densely populated district/unitary in the country. The county is markedly rural and dispersed, 48% live in the countryside, with border-to-border travel times east to west of two hours, and north to south of one hour.

1.2 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 with 10.4% of the population over 75 years of age compared to 7.8% in England. 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.

1. 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. The county has no large urban areas, or universities.

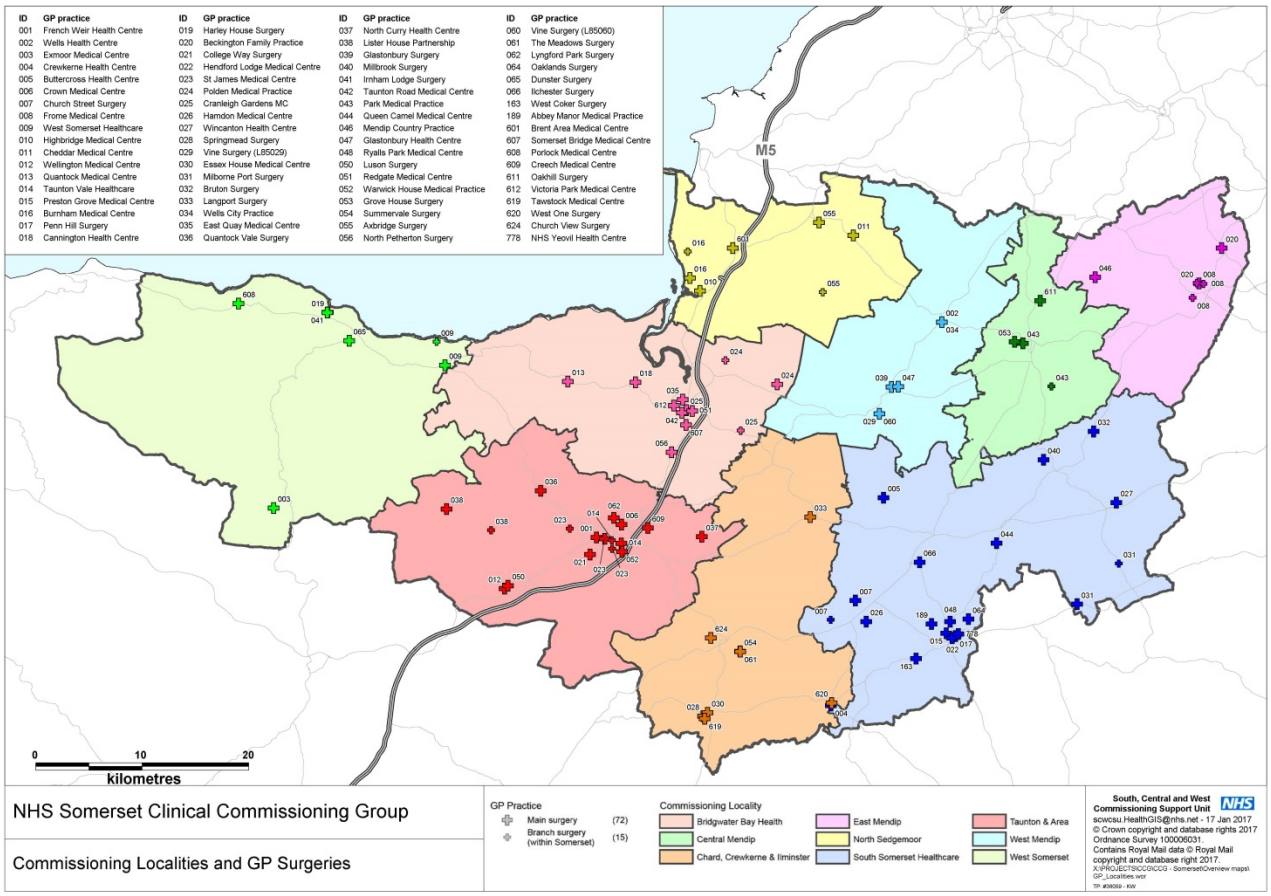
1.4 Overall life expectancy for Somerset residents is approximately two years higher than the national average. Over the past decade, death rates from all causes have decreased and those from coronary heart disease and cancer are lower than the national average. This demographic profile presents complex challenges. The ageing population and gap between life expectancy and health life expectancy is driving an increased demand whilst the reducing working age population is further diminishing our labour market.

1.5 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.

1.6 The profile of service provision across the county is:

- 222 community hospital beds
- 827 general beds across 2 District General Hospitals (DGHs)
- 71 GP Practices across 9 localities (there was one Practice merger which has reduced the total number from 72 in 2016/17)

1.7 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 70 Member Practices are located within the County Council boundary, and can align themselves to one of nine localities as depicted:



1.8 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.

1.9 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 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

1.10 Tackling health inequalities and being focused on advancing equality has been a key strategic aim of Somerset CCG during 2017/18.

1.11 In addition, the CCG has been working with partner organisations on the Somerset Sustainability and Transformation Plan to introduce new models of care which will form the foundation for how services are commissioned for Somerset in the future. The Sustainability and Transformation Plan for Somerset has been developed since 2016/17 and this sets out the case for change and the priorities that must be achieved. We want to encourage collaboration and integrated working arrangements across providers.

1.12 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)

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

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

1.15 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. The report will cover the following key workstreams:

- Diabetes Prevention
- Person Centred Care
- Primary Medical Care
- Community Services
- Urgent and Emergency Care
- Elective Care and Acute Services
- Cancer

- Mental Health
- Learning Disabilities
- Medicines Management
- Maternity Services
- Nursing Home Support Services
- Infection Prevention and Control
- Enablers – Workforce, IT and Digital, Estates
- Developing the STP

Diabetes Prevention

Summary of key priorities for Diabetes Prevention for 2017/18 to 2018/19:

1.16 In order to achieve the greatest gain in health and wellbeing, there will be a particular focus on preventing the five diseases/conditions shown below that pose the most significant burden to the population and health and care system. These have been identified and agreed using a prioritisation tool through the STP prevention workstream: Mental Health and Dementia; Cardiovascular and metabolic disease; Cancer; Respiratory Disease; Muscular-skeletal conditions and falls.

What we did in 2017/18:

- the Prevention Charter was signed up to by all organisations
- the Diabetes Local pathway group implemented:

    - digital diabetes prevention programme (one of 8 first wave sites in England)

    - worked collaboratively with My Digital Health and the University of Dundee to achieve a successful funding partnership with SBRI to firstly pilot My Diabetes My Way and subsequently roll the programme across Somerset

    - piloted virtual clinics as part of an integrated model of care

    - developed an integrated model of care for diabetes

    - achieved NHS Transformation funding for acute nursing transformation which has reduced length of stay and the number of hypoglycaemic episodes in hospital. The project has also addressed diabetes management in community hospitals

    - agreed a consensus on the use of low carbohydrate diets in the management of diabetes

    - diabetes workshops have been held across Somerset to develop an integrated model of care

- diabetes virtual clinics were piloted as part of the 100 day project. This indicated 74% of patients did not need to be referred to hospital. Clinicians benefited from shared learning

1.17 During 2017/18 the STP changed its focus in terms of prevention. As part of the prevention work across the system the need for this to be considered as part of the 3 year financial plan has become apparent due to the issues with funding prevention schemes in year and seeing a return of investment within the year.

1.18 In 2018 the diabetes programme will:

- implement a face to face diabetes prevention programme
- roll out My Diabetes My Way in Somerset
- implement a pilot of remote access structured education
- implement a new integrated model of care for diabetes to include virtual clinics

1.19 With regard to prevention as a whole this will now be a key focus for the Somerset Health and Care Strategy. Within the workstreams there will be strong public health involvement to ensure that primary, secondary and tertiary prevention is embedded into new pathways of care at all stages, as well as specific focus on improving health and wellbeing as a key focus in its own right.

Person Centred Care

Summary of key priorities for Person Centred Care for 2017/18 to 2018/19:

- continue to support the development of the Somerset House of Care
- continue to support and share best practice of New Care Models
- increase joined up working across organisations to better support and care for people – more Children and Young People (CYP) with Special Educational Needs and Disabilities (SEND) have Education Health and Care Plans (EHCPs).
- educate people in better self-management of their conditions
- support interoperability of computer systems between different health and care services
- Better Care Fund schemes

What we did in 2017/18:

- the number of services using Patient Activation Measures (PAM) has increased, with 3,555 patients having completed a PAM by November 2017. The PAM is a measure of the extent to which individual patients are involved and helping to control their health condition.

- a further 78 staff have completed the House of Care Training, with 82% of practices having participated
- two cohorts of staff received enhanced Motivational Interviewing training, with very positive results
- we have worked collaboratively with the Richmond Group to develop an at-scale approach to social prescribing, we have also funded local directories of voluntary sector services

1.20 Looking ahead to the coming year the CCG will be:

- ensuring Person Centred Care remains a strategic priority, with the focus in 2018/19 moving from supporting operational practice in core NHS services to supporting the development of new ways of working that are asset based and build on stronger communities.
- supporting the Richmond Group's roll out of Social Prescribing
- working collaboratively with SCC to further embed Integrated Personalised Commissioning
- working collaboratively with SCC to develop web based portals for self-management advice and signposting to community assets
- continuing to extend the number of Personal Health Budgets (PHBs) per 1000 population across all groups 6 PHBs per 1000 population including new cohort with EHCPs
- ensuring that strong personalisation is a key requirement within the options developed within the Health and Care Strategy in 2018

Primary Medical Care

Summary of key priorities for Primary Medical Care for 2017/18 to 2018/19:

- GP Improved Access
- improving the workforce position
- joined up care arrangements between GP services, community services, community pharmacies and hospitals
- supporting self-care
- improving technology including shared records and online booking

What we did in 2017/18:

- **Improved Access:** GP Improved access is a standalone service that offers pre-booked and same day appointments on a locality basis from 6:30pm – 8pm on weekdays and at weekends to meet local population needs. The CCG achieved 100% population coverage for this initiative by July 2017. As at quarter 3 in 2017/18, 85% of the 16,344 improved access appointments were booked across the county.

- **GP Workforce:** Somerset's GP Carers Plus pilot supported around 10 GPs to continue working in the county. The Somerset scheme

was recognised by the Secretary for Health as an example of good practice. A Somerset bid for the International GP Recruitment scheme was submitted to NHS England and we are currently awaiting a response to know whether we have been successful.

- **Innovation by Somerset practices**: A sample of innovations by Somerset practices have been published and shared with practices on the Bright Ideas Section of the Local Medical Committee's website. https://www.somersetlmc.co.uk/brightideas . These include the deployment of pharmacists, paramedics and health coaches, extended roles for Advanced Nurse Practitioners, joint working between practices and the voluntary sector, workflow and better access arrangements for patients. The innovations have been developed to support practices in developing the way in which they provide services to patients as well as improved the resilience of the practice.

- **Clinical Pharmacists:** A number of practices have introduced clinical pharmacists within the practice, either through the national clinical pharmacist scheme or through their own local arrangements. These posts are providing more direct access to patients for advice about their medications, helping to support some patients with long term health conditions and releasing time for GPs.

- **Joint working with local pharmacies:** Somerset CCG has commissioned 88 community pharmacies within Somerset to provide the Minor Ailments Scheme enabling people with minor health conditions to access medicines and advice that they would otherwise visit their doctor for. The conditions are localised impetigo, acute superficial bacterial eye infections and uncomplicated acute urinary tract infection. Local workshops have been run by the CCG, Local Medical Committee and Local Pharmaceutical Committee to consider closer joint working between practices and pharmacies in future. A positive outcome from the workshops is agreement to pilot the use of EMIS viewer by named pharmacists in a number of local pharmacies. This will allow named staff to view aspects of the patients' primary care record with the patient's consent at the point of care. It will be approached in the same way as it has been used in A&E departments, MIUs and other care settings.

- **New models of care:** Somerset CCG supported a continuation of test and learn schemes in a number of areas of the county which are testing out new models of primary care. These include more coordinated multi-agency support for patients with complex long terms conditions, social prescribing and the development of a wider range of support groups and networks for patients. The schemes are:

  - South Somerset Symphony
  - Taunton Symphony

- Mendip Symphony
- The West Somerset Living Better Scheme
- The North Sedgemoor Village Agent Scheme

- **Resilience:** The CCG has made funds available to groups of practices to support a range of initiatives including mergers, efficiencies, shared staffing and new staff roles such as care navigators. The groups of practices are currently implementing these proposals and starting to see the benefits within the practice. No practices closed in 2017/2018.

- **Information Technology**: The CCG has made good progress with patient online access to booking and repeat prescriptions. The CCG also launched a major programme to share records across the health and care system, SIDER (Somerset Integrated Digital Electronic Record).

- **SPQS**: For 2017/18, 52 out of 70 practices participated in the local alternative to the national Quality and Outcomes Framework, the Somerset Practice Quality Scheme. The main emphasis of the scheme was on quality improvement in the context of joined-up person-centred care. Somerset has actively contributed to the national review of QOF and agreed to commission a local alternative to the national Quality and outcomes Framework for 2018/2019.

- **GP Enhanced Services**: During 2017/2018, 41 practices signed up to the CQUIN, embedding the 'Making Every Contact Count' principles and ethos into their practices. All enhanced services have been reviewed for efficiency and aligned to Individual Funding requirement policies, where appropriate.

- **Premises:** The Estates, Technology and Transformation Fund project to extend the first floor of French Weir Medical Practice in Taunton, supported by a grant of £490k, is progressing with completion planned for 2019. The extension will provide additional capacity and opportunities for further collaborative working with St James Medical Centre. Minor improvement grants have been issued to a number of practices within Somerset to enhance the current environment.

1.21 Key plans for 2018/19 include:

- **Workforce strategy:** primary care workforce will be considered as an integral part of the Somerset-wide workforce strategy. The aims are to bolster GP and nurse numbers and continue to support a wider range of other professionals to be part of the primary care team as well as supporting a continuation of the GP Careers Plus scheme in collaboration with the Somerset Education Trust, Somerset Primary Healthcare Ltd and the local Locum Agency. We will continue to actively pursue initiatives to improve GP recruitment

and retention and the development of the primary care workforce such as bids for international recruitment and further developing portfolio working.

- **Innovation:** The CCG will continue to promote and publish innovations by Somerset practices in their use of broader groups of professions and in making changes to the way the practice runs and services are offered to patients.
- **Resilience and sustainability:** The CCG will work with NHS England and the Local Medical Committee to proactively support practices who become worried about their sustainability in order to implement changes and to work with other practices or local partners to ensure that high quality services can continue to be provided to patients. Resilience funds have been committed to support the implementation of this work.

- **New models of care:** The CCG will continue supporting the test and learn schemes and draw together key outcomes from the models to inform elements of the new Health and Care Strategy.

- **Local Networks:** The CCG will develop locally integrated care, bringing GPs, community nurses and others together to serve a defined population of around 30,000 to 50,000 people. The CCG will invest £3 per head of population in initiatives that will improve the efficient organisation of GP services and provide better outcomes for patients.

- **Online consultations:** The CCG is currently procuring a technical service which will allow patients to access online consultations. We will launch and learn from this in 2018/19.

- **Delegation:** The CCG will develop plans to move towards delegation of the commissioning of primary medical services from April 2019, as well as maximising the opportunities available through our current joint commissioning arrangements.

Community Services

Summary of key priorities for Community Services for 2017/18 to 2018/19:

- support the engagement, implementation planning and the Hospital at Home services, including monitoring of the impact of quality and effectiveness on the whole system
- extend the flexible use of Community Hospital beds to ensure capacity matches demand for in-hospital services, and contributes to a system wide move to home based support
- extend the range of ambulatory services which support people to receive their treatments closer to home whilst remaining living at home

What we did in 2017/18:

- Community Hospital beds used flexibly, with cohorting of beds into larger units to maintain staffing resource, ensure quality and safety of services and bed availability throughout the year

- Discharge to Assess services developed and implemented from October 2017, to increase the number of people who have timely discharge and increase home based care

- escalation beds in Community Hospitals were deployed during winter 17/18, but were managed at low levels due to the proactive use of Discharge to Assess schemes

- During 2017/18 the STP recognised the need to review how community services operate across the system and incorporate this into the Health and Care Service Review.

1.22 The work programme has focused on:

- new models of community care need to be planned in stronger collaboration with social care services, and, be co-produced with the public and staff groups. Therefore, this will form part of the Health and Care strategy work programme in 2018

- the evaluation of Discharge to Assess will support and contribute to understanding needs and the evidence base for further home based care , including the workforce development and use of new roles in health and care

Urgent and Emergency Care

Summary of key priorities for Urgent and Emergency Care for 2017/18 to 2018/19:

- deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan
- by November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services
- implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health will be implemented by March 2020 in the STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls
- deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department
- initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis

What we did in 2017/18:

- Somerset A&E Delivery Board for System Wide Urgent and Emergency Care supported the priorities for Urgent Care which were identified by the STP

- Musgrove Park Hospital implemented Emergency Department (ED) Streaming on 3 April 2017 and Yeovil District Hospital implemented on 2 October 2017

- SWASFT have embedded the Ambulance Response Programme
- Clinical Assessment Service (CAS) Test and Learn pilot took place from December 2017 to March 2018

- winter plan developed and implemented. Planning for 2018/19 will pick up growth assumptions, performance targets, bed capacity and length of stays

- both Somerset acute providers continue to review patients who present in A&E with mental health needs to establish where further support is required. This is in line with the CQUIN for A&E and will continue into 2018/19

- Effectiveness of 111 and out of hours services compromised by quality and safety issues which impacted on urgent and emergency care provision. Short term change in operational arrangements put in place, pending further strategic change

What we will achieve in 2018/19:

- work continues to support providers to deliver the 4 hour A&E standard and standards for ambulance response times
- both Somerset acute providers have plans in place to deliver the priority standards for seven-day hospital services
- work continues to reduce the proportion of ambulance 999 calls that result in conveyance to an A&E department
- Integrated Urgent Care (IUC) service procurement to take place and service will commence February 2019
- direct booking pilots to take place within Primary Care
- continued development of the CAS and implementation of NHS 111 Online
- ongoing implementation of Urgent and Emergency Care Delivery Plan ensuring that milestone targets are progressed

Elective Care and Acute Services

Summary of key priorities for Elective Care and Acute Services 2017/18 to 2018/19 (including referral to treatment targets and delayed transfers of care):

- delivery of the constitutional standards, achievement of 92% Referral to Treatment (RTT)
- managing demand and driving efficiencies to release additional capacity within the system to enable us to provide equitable access for patient care within the constitutional standards
- develop a new and efficient orthopaedic pathway which will deliver RTT compliance
- finalise new service models for dermatology
- agree new delivery model for Musculoskeletal services (MSK)
- develop and enhance current model for outpatient follow up appointments, linking to Follow up outpatient appointment reform
- continue with plans to tackle delayed transfers of care (DToC)

What we did in 2017/18:

- GP Referral Variation initiative / programme has reported a 6% referral reduction at practice level by September 2017
- created new policies for Cataracts, Cholecystectomy, Carpal Tunnel, Hernia (Adults), Hip Replacement, Varicose Veins, Tonsillectomy, Myringotomy
- Patient Initiated Follow Ups (PIFU) as part of the Follow Up Reform initiative has implemented PIFU across 14 plus specialties. This has resulted in an average of 72% of Patient Initiative Follow Ups offered not being initiated by the patient, releasing capacity within outpatients.
- programme and governance structure set up to review areas identified by Right Care data. The programme of work falls under the system-wide Clinical Variation programme. The Falls & Frailty project has made significant progress in delivering
- new Orthopaedic pathway implemented. System has one lead provider for the delivery of the Orthopaedic Assessment Service in Somerset (OASIS) service.
- continue to collaborate with providers to improve delivery of Constitutional Standards with particular focus upon reducing the number of long waits
- Dermatology service delivered in the west of the county by UHB. This includes services offered within Somerset and Bristol for 2 week waits. The GP with Special Interest (GPwSI) service continues to provide routine dermatology services. Investment has been made within the GPwSI service and additional GPwSI capacity has been commissioned from Clare House Tiverton. Teledermatology has also been rolled out and has started to be used across Somerset practices
- Home First Discharge to Assess Test and Learn commenced on 4 September 2017, this enables patients to leave hospital rather than

waiting on the ward for care assessments and rehabilitation planning, which can take time. Instead they receive those assessments and support at home, or in a specialist unit, care home or community hospital, to get them back on their feet

What we will achieve in 2018/19:

- maintain sustainable pathway for MSK (Q1 2018/19). In addition identify clinical variation to aid demand and capacity challenges
- system-wide collaborative and co-ordinated response to sustain Dermatology Service across Somerset (March 2019)
- continue to monitor and manage demand, through the GP referral variation work programme
- continue to collaborate with providers to improve delivery of Constitutional Standards within Planned Care
- ongoing development of driving efficiencies through the identification of clinical variation opportunities including the continuation and embedding of the patient initiated follow up initiative, plus virtual clinics, telephone clinics
- mainstream the Discharge to Assess (D2A) 'Home First' pathway to sustain DToC position of 3.5%

Cancer

Summary of key priorities for Cancer for 2017/18 to 2018/19:

- direct access to diagnostics
- deliver an improvement in cancer diagnosed at stage 1 or 2
- achieve constitutional standards and Cancer waiting times targets including 62 day waits

What we did in 2017/18:

- initial discussions have commenced in implementing direct to test pathways
- some improvements have been made to the colorectal pathway around integrating complex care teams at Taunton
- head and neck has an improved pathway for cancer patients
- the STP are working on centralising oncology
- reviewed advice given to patients

What we will achieve in 2018/19:

- funding has been received for implementation of the cancer recovery package which will be rolled out across Somerset
- implement direct to test for colonoscopy

- implement Faecal Immonochemical Test (FIT) testing for screening patients (in association with Public Health England)
- implement FIT testing for symptomatic patients (funded project)
- implement optimised lung cancer pathway (funded project)
- review variation in cancer pathways

Mental Health

Summary of key priorities for Mental Health for 2017/18 to 2018/19:

- Children and Young People's Services – to ensure access to 30% patients requiring 2 NHS funded services. To commission a 24/7 urgent and emergency service mental health service for Children and Young People (CYP)
- for 95% CYP to receive routine treatment within 4 weeks of assessment and 95% of urgent referrals to receive treatment within 1 week
- increase Access to Psychological Therapies to 16.8% of people with common mental health conditions and achieve a recovery rate of 50%
- Early Intervention in Psychosis – 50% of people experiencing a first episode of psychosis to be treated within 2 weeks
- to increase physical health checks 60% of people with serious mental illness
- to increase access to Individual Placement Support services in an employment support scheme
- to increase dementia diagnosis to 66.7% of people with dementia, and to increase post diagnosis care
- to develop multi agency action plans and reduce suicides by 10% by 2021

What we did in 2017/18:

- achieved 95.5% for CYP eating disorder services within 4 weeks and 94.4% waiting times for *urgent* referrals to CYP eating disorder service within 1 week

- the Early Intervention in Psychosis service delivered the 50% target within 2 weeks in quarter 3

What we will achieve in 2018/19:

- improved Commissioning Specifications with clear key performance indicators to ensure Somerset meets the *Five Year Forward View* Delivery Plan targets
- to ensure mental health services meet the national core fidelity standards for capacity and service e.g. For Community MH service,

Crisis Resolution and Home Treatment Team, Early Intervention in Psychosis

- Parity of Esteem funding to meet the *MH Investment Standard* will increase funding to the CYP Community Eating Disorders Service, IAPT, Early Intervention in Psychosis, Crisis Resolution and Home Treatment, Annual Health Checks for serious mental illness, ADHD diagnosis and Community Forensic Services for people with Learning Disabilities
- MH Commissioning Team to begin performance managing the Psychiatric Liaison Service to ensure it develops towards the Core 24 fidelity model and works in tandem with the Crisis and Home Treatment Team
- to achieve 32% access rate for CYP Mental Health services and fully implement the CAMHS Transformation Plan
- increase Access to Psychological Therapies to 19% and recovery rate by 50%
- to agree Dementia Diagnosis pathway and enable General Practice to increase diagnosis rates
- improved access to perinatal and infant mental health

Learning Disabilities

Summary of key priorities for Learning Disabilities for 2017/18 to 2018/19:

- refresh of the Transforming Care Plan for 2017/18
- creation of bespoke community placements: promoting choice such as home ownership within the local market
- develop a Somerset framework for reviews of deaths of people with learning disabilities working with the LeDeR project
- increase joint working across health and social care using the SAF (Self-Assessment Framework)
- engage with Children's services to ensure an All Age Transformation Care Programme
- develop the Somerset LD Partnership Board – started in Sep 2016 and ongoing
- adherence to robust Care and Treatment Review process as well as a Care, Education and Treatment Review process

What we did in 2017/18:

- five Peer support groups set up. Groups provide safe community space to enable people with LD to talk about experiences and share views. Representatives attend the LDPB giving people with LD a stronger voice
- the new Somerset Transforming Care Partnership (TCP) Board has oversight and is responsible for the TCP plan

- Somerset TCP has been successful in obtaining capital funding for six properties (two in 2016/17, one in 2017/18 and three for 2018/19). Two patients have move in and a further property has been purchased to date. Planning has started for the others
- we have 14 trained mortality reviewers in Somerset. Eleven reviews are in place. A steering group is in place and is focussed on recruiting another cohort of review staff and trainer the trainer sessions are planned
- a medication audit has taken place. The current Easy Read reducing medication leaflet is being updated

What we will achieve in 2018/19:

- we will continue with closer joint working between SCC and the CCG and other stakeholders. We are planning to write a joint LD strategy for 2018/19
- planning has started for 2018/19 capital bids and Somerset TCP will work closely with patients and families to ensure the housing and required specifications are person-centred and fit for purpose
- discharge planning for eligible Transforming Care inpatients – the aim will be to reduce NHS England Specialist commissioning patients from 10 to 4 by March 2019, and reduce CCG commissioned inpatients from 5 to 0 by March 2019
- a LeDeR steering group/framework is in place but further work is required to engage with stakeholders, communication of plans and training more reviewers.

1.23 In addition in 2018/19:

- SCCG and SCC commissioners are actively looking to develop a new 'market place' of support for people in the transforming care group. The TCP will work with providers who can build bespoke services around the individual to increase their independence and become part of the local community

- further work on the development of an all age Admissions Avoidance Register to prevent hospital admissions

- further work on access to Annual Health Checks of which the LD Register is an important tool, the CCG is planning to review this register

- ensuring that the Care and Treatment Review process is robust

Medicines Management

Summary of Other Priority Areas for 2017/18 to 2018/19:

- Medicines management and implement guidance on the 18 ineffective and low clinical value medicines and the impact of any developments concerning over the counter medications following consultation

What we did in 2017/18:

- Somerset CCG remains one of the lowest spending CCGs in the country on prescribing (<5th percentile)

What we will achieve in 2018/19:

- Implement the guidance on the 18 ineffective and low value medicines and any developments concerning over the counter medicines but will continue to monitor and feedback additional NCSO costs should this assumption not be realised

Maternity Services

Summary of key priorities for maternity services for 2017/18 to 2018/19:

- the National Maternity Review, Better Births, was published in February 2016 and set out a clear vision: for maternity services across England to become safer, more personalised and more family friendly
- Better Births recommended that commissioners and providers work together across areas as Local Maternity Systems (LMS) across footprints of 500,000 to 1.5 million people, aligned to Sustainability and Transformation
- the key priority is to implement the 'Better Births' plan

What we did in 2017/18:

- the LMS Programme Board was established in June 2017 and identified actions needed to meet the recommendations of Better Births, and identified action leads from across the system

- Maternity Transformation Programme – implementation of Better Births is underway. Somerset is a Better Births Early Adopter, focussing on Digital (paper light) and new Maternity Support Workers (nursing associates). Somerset Local Maternity System Programme Board has a full Better Births Action Plan

What we will achieve in 2018/19:

- Better Births action plan in place which includes delivery of:

    - deliver improvements in safety towards the 2020 ambition to reduce stillbirths, neonatal deaths, maternal death and brain injuries by 20% and by 50% in 2025, including full implementation of the Saving Babies Lives Care Bundle by March 2019
    - increase the number of women receiving continuity of the person caring for them during pregnancy so by March 2019 20% of women booking receive this
    - continue increase in access to specialist perinatal mental health services, ensuring that an additional 9,000 women access specialist perinatal mental health services and boost bed numbers in the 19 units that will be open by the end of 2018/19 so that overall capacity is increased by 49%
    - by June 2018 agree trajectories to improve the safety, choice and personalisation of maternity

Care Home Support Team- renamed Nursing Home Support Service (NHSS)

Summary of key priorities for NHSS for 2017/18 to 2018/19:

In 2015 Somerset Clinical Commissioning Group commissioned the Nursing Home Support Service to support nursing homes to improve quality and reduce avoidable hospital admissions. The service comprises professionals including a Registered Nurse and a Social Worker.

During visits, the service can provide 1:1 support to managers; awareness raising workshops for entire staff teams with pressure ulcer prevention, training and revalidation, safeguarding, mental capacity, Deprivation of Liberty Safeguards (DOLS) and person cantered Care Planning.

Learning Engagement Meetings are run quarterly with acute trusts and nursing homes it has now been opened to Residential Homes and ward staff supporting the whole health economy, disused are issues with hospital admissions and discharges are discussed and potential solutions, guest speakers are invited in relation to topics causing admissions e.g. sepsis, stroke, hydration.

What we did in 2017/18:

Collaborative work with the Hospice EOL training for Nursing homes has been a success, Attendees stating they have avoided admissions and feel more confident when communicating with other medical professionals, this is now being duplicated on the East of the county, the service are also supporting the Dying Matters Conference hosted by the hospice.

The service produce a bi monthly newsletter for the nursing homes and Residential homes, highlighting relevant evidence based practice, resources, learning opportunities and promotes commissioned service.

Over the year, the team have supported 53% of nursing homes in Somerset and completed 70 visits. From a review of Quality Assurance Framework it indicates within a 3 Month period:

- 13% of homes expressed the service reduced admissions
- 47% reported the service supported improving the quality of Care
- 33% reported the service had supported them in reducing risk
- 13% Reported Improved Discharges

Nursing homes are able to self-refer for support by telephone/email. If you are working with a nursing home that may benefit from the team's support, please advise them of this before contacting us at chs.team@somersetccg.nhs.uk

What we will achieve in 2018/19:

- To raise awareness of Sepsis in Nursing Homes and the benefits of using NEW2 to support clinical decision making and the use of the same language across the healthcare economy.
- The Service foresees this training being able to be completed via Podcasts, Webinars and Video's
- Supporting the Red Bag Scheme
- Supporting the role out of the STEP within Care Homes, ensuring there is training to support the correct use and understanding of this tool.

Enablers – Workforce

Summary of key priorities for workforce for 2017/18 to 2018/19:

- to address key supply challenges in primary and urgent care, cancer, maternity and mental health and in the direct care workforce, the Somerset Local Workforce Action Board has recently commissioned a workforce strategy and programme of rapid improvement. Four workstreams are being developed to:

    - accelerate the development of a wider skills mix in primary care
    - stabilise the direct care (and wider support) workforce
    - improve retention and recruitment and
    - create whole system approaches to leadership, organisational development and talent management.

- this programme of work and the longer-term strategy is aligning closely with the development of Somerset's Health and Social Care plan, and solutions to workforce supply issues will be 'designed in' wherever possible to the review of clinical pathways

What we did in 2017/18:

- worked in localities to understand and begin to solve supply issues by changing skills mix
- developed plans further and began to seek an appropriate university partner
- an innovative and effective recruitment campaign for social workers (www.socialcareandmore.co.uk)
- in conjunction with HEE SW introduced a strategic workforce planning tool (WRaPT) for key rapid response and DToC services

What we will achieve in 2018/19:

- accelerated development of primary care skills mix to address supply issues
- focus on nursing – demand and capacity review now commissioned, work with identified partner to define course offers
- retention needs to be strengthened to address high turnover rates in the direct care workforce
- the workforce strategy recently commissioned will develop a full high level model identifying all key skills mix changes and development needs

Enablers – IT and Digital

Summary of key priorities for IT and digitally enabled change for 2017/18 to 2018/19:

- to lead the Somerset Digital Roadmap development. To deliver the vision and objectives the Somerset Digital Roadmap identifies four key work areas:

  - a paperless system, with shared records and interoperability
  - person facing services and digital inclusion
  - real-time data analytics at the point of care
  - whole systems intelligence

What we did in 2017/18:

1.24 A new service called SIDeR (Somerset Integrated Digital electronic Record) is being rolled out across Somerset over the next few years to allow GP practices, hospitals and Social Care to securely view your health and care information.

1.25 This new technology will help us to link up our existing IT systems that record and securely store patient information, so that medical and care staff can view the information to help them deliver better and safer care. For example, they will be able to see details about medications, allergies, appointments and care plans to help understand the exact needs of each patient.

1.26 The key achievements in 2017/18 are:

- Estates and Technology Transformation Fund (ETTF) funding awarded to Somerset to support the Digital Roadmap
- organisations reviewed Digital Maturity Self Assessment (DMSA) annually via NHS England
- programme in place to deliver GP IT Services via SCW CSU
- Business Intelligence overview plan of themes and programmes developed
- national standards including Fast Health Interoperability Resources (FHIR) and MESH are being utilised for transfer of information
- preparation underway for the implementation of a new clinical coding tool known as SNOMED
- withdrawal of MiQuest to be replaced with a new product provided by the GP Clinical system provided by EMIS Health Analytics
- established Digital Steering , Working, and Information Governance Groups across all partners in Somerset
- maintained stakeholder engagement with primary care teams via IT Leads, the Local Professional Committees for medical, optometry and pharmacy

- early engagement with Care Homes and Community Council for Somerset (including Village Agents) on the digital agenda and improving information flow
- pilot funded for wearable technology to support the balance and safety group in association with Somerset Partnership NHS Foundation Trust
- continued engagement with PPG Chairs and SEAG Groups
- patient representative on SIDeR Procurement
- updates on digital programme shared with GB and COG
- 22% patients signed up for GP Online services across Somerset
- Child Protection Information Sharing (CPIS) system went live which supports the safeguarding of children being seen in emergency care settings
- EMIS Viewer phase 2 rolled out to all clinical areas and further organisations
- SIDeR 3 year Contract awarded to Technical Partner to join up Somerset IT systems to enable sharing of information for direct care
- cleansing of End of Life records
- 88% Practices live with Electronic Prescription Service (EPS)

What we will achieve in 2018/19:

- delivery of ETTF Schemes: Extended Access, One Domain and SIDeR (as below)
- SIDeR Programme – Technical Partner plan for 9 key deliverables starting with End of Life from Spring 2018
- Digital Support to UEC Programme including 111 Online, Direct Booking, Bed Management, Integrated Urgent Care (IUC) Strategy, EPS, diabetes prevention programme
- GP Online (Repeat prescriptions, appointments, Detailed Coded Record Access – extend use by patients across Somerset
- EPS – optimise use with a focus on Electronic Repeat Dispensing (eRD) and support dispensing practices to implement when functionality available
- EMIS Viewer – optimise use across all clinical care settings, and explore Phase 3 potential
- explore opportunities for use of data to inform improved care provision and service planning
- explore potential to improve information sharing as patients travel across the wider South West region
- public access Wi-Fi at all general practices in Somerset by summer 2018
- continued engagement with members of the public and community groups on the development of the digital programme
- support further range of clinically led initiatives emerging through the Clinical Health and Care Strategy

Enablers – Estates

Summary of key priorities for Estates for 2017/18 to 2018/19:

- benchmark estates and develop an estates strategy for Somerset
- supporting the development of a capital bid to enable the rebuilding of the surgical centre at Musgrove Park Hospital in Taunton

What we did in 2017/18:

- completed the benchmarking exercise to provide a database of local estate
- the Estates Strategy workbook was submitted to NHS England on 31 January 2018
- capital bid submitted to NHS England to support the priority of developing a new surgical centre at Musgrove Park Hospital by the end of 2023 that will incorporate new theatres and critical care facilities. The bid was approved by the Department of Health at the end of March 2018

What we will achieve in 2018/19:

- review the estates priorities as part of the clinical services review in order to ensure that the plans for service transformation are supported by appropriate estates and facilities

Enablers – Developing the Somerset Sustainability and Transformation Plan

1.27 Somerset CCG has been working with its partners over the previous year to move to an Accountable Care System for Somerset. As commissioners of health we know this must happen to ensure a sustainable system in the future and continue to be committed to working together as a system to achieve this.

1.28 To deliver transformational change required in Somerset we recognise that an alternative approach to commissioning services is required. We want to encourage collaboration and integrated working arrangements across providers.

1.29 The Sustainability and Transformation Plan demonstrates the case for change within Somerset and we know services in the county are not keeping pace with the changing needs of local people and it is becoming increasingly difficult to ensure access to consistently high quality care that is affordable and sustainable.

1.30 The Sustainability and Transformation Plan sets out a number of priorities over the five years until 2020/21 and Somerset CCG is committed to working with our system partners to achieve these priorities. Each priority

area has a lead accountable officer who is accountable to the System Leadership Group which is led by an independent Chair:

- driving Improvement in the in-year system-wide financial and performance position
- focus on prevention to develop a sustainable system
- redesigning out of hospital services
- address clinically and financially unsustainable acute services provision
- developing an Accountable Care System for Somerset

1.31 As part of the developing and continued working towards a single system on the financial, activity and workforce the individual operational plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery, in 2017/18 and forwards from here.

1.32 The Somerset approach to managing the system as a single health and care system, supported by a long strategy is being developed, with the more immediate development of a three year financial recovery plan, to ensure alignment and delivery of the triple aims for the system as a whole. This forward strategy will build on the already STP approved estates workbook, capital plans, and digital plans.

1.33 The recovery plan will focus on managing demand and reducing cost across the system. This will include a focus on clinical variation (using Rightcare, Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks) is looking at elective and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care.

1.34 During the refresh of 2018/19 plans the Somerset STP leadership has jointly worked through the assumptions and plans for the future, including the agreement of standards and levels of care that are expected to be delivered.

Performance Analysis

Sustainable Development

1.35 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. The CCG monitors the plans that Providers have in place through the standard NHS Contract (ref SC18) to demonstrate their progress on sustainable development. 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.

1.36 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

Improve Quality

What we did in 2017/18:

- workforce planning, drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services
- Sign Up to Safety pledges and priorities for change and improvement
- Quality Equality Equity Impact Assessment to ensure services changes are consistently assessed
- participate in the annual publication of findings from reviews of deaths, including avoidable death rates
- establish the Learning Disabilities Mortality Review (LeDeR) programme in Somerset, which reviews the deaths of people with a learning disability
- review of safeguarding arrangements for vulnerable people
- improving mental health for people in crisis and children and young people
- using existing methodology to monitor Emergency Department (ED) overcrowding through the SHINE project

- assessment of Frailty using the Rockwood scale
- support meeting the needs of older people
- transform our approach to clinical quality monitoring across Somerset system

What we will achieve in 2018/19:

- embed a system wide new approach to Clinical Quality Review Monitoring meetings through the introduction of Virtual monitoring against the Quality Schedule and implement a system wide Quality Assurance and Safety Network – this will support greater system working to drive quality and patient safety
- work with services to ensure learning from death reviews lead to change and improvement
- design and consult on a Quality, Safety and Improvement strategy for Somerset to drive continuous improvement across the quality and patient safety agenda
- establish a clinical senate to balance the financial decision making across Somerset

Infection Prevention & Control

Somerset CCG has maintained a strong focus on reducing health care acquired infection.

Clostridium *difficile* (C.*diff*)
Somerset CCG is under trajectory for C diff cases with a total of 126 cases in 2017/18 to date against a target of no more than 131 cases.

MRSA
Zero tolerance approach. There has been a total of 13 MRSA BSIs in 2017-18 to date of which 3 were acute trust onset. A post infection review took place on each case to identify why the infection occurred and how future cases can be avoided.

E *coli*
There is a national ambition to reduce Gram-negative blood stream infections by 50% by March 2021. The majority of E coli bloodstream infections occur in the community, and a whole health economy approach is required to achieve the reductions required.

A CCG led Somerset county wide reduction action plan and working group is in place, with representation from acute and community trusts, primary care, microbiologists, antimicrobial pharmacists and PHE. As urine is the source of 50% of all E coli BSIs, the group has agreed the following 3 key objectives for 2017/18:

- Reduce the risk of and improve the management of UTIs
- Reduce prevalence of indwelling urinary catheters
- Improve urinary catheter care

Outcomes to date:

- Somerset CCG is currently over trajectory to achieve the first year 10% reduction, with a total of 499 cases in 2017-18 to date.

Complaints

Somerset CCG values complaints, which are vital to continuously improve the quality of local health services and a measure of how services interact and are coordinated across the patient pathway. Formal complaints are captured, investigated, analysed and categorised.

During 2017/18 Somerset CCG received a total of 119 formal complaints. The main themes arising from these complaints were:

- dissatisfaction with the NHS Continuing Healthcare (CHC) assessment and application process
- delays with NHS 111/out-of-hours service
- dissatisfaction with the wheelchair service

Engaging People and Communities

Patient, Carer and Public Engagement

1.37 Between April 2017 and March 2018, the CCG undertook a range of public engagement through the following conduits.

1.38 The Somerset Engagement Advisory Group (SEAG) is a key forum where the CCG engages with the voluntary and community sectors, Healthwatch, patient and carer groups and the County Council on a quarterly basis. Following on from SEAG's role as part of the Sustainability and Transformation Plan public engagement workstream, the group formally agreed in 2017-18 to play a key role in public engagement for the Health and Care Strategy. SEAG has strengthened its links with a wider range of voluntary and community sector partners, including social care service users, Community Ambassadors, mental health hubs and initiatives, Village and Carer Agents, Healthwatch, League of Friends, parent carers and Carers' Voice.

1.39 SEAG has continued to both challenge and support the CCG in widening participation and representation. Over the past year, the group has contributed to a wide range of system-wide areas of work, including procurement processes, improving commissioning practices across health and social care, young people's mental health, continuing health care, gypsy and traveller health, outcomes-based commissioning, the Sustainability and Transformation Plan, the Equality Delivery System, BME engagement, the Joint Strategic Needs Assessment, the involvement of social care service users, League of Friends, Community Ambassadors, online counselling services, digital healthcare, parent carers, and the strategic direction of health and care commissioning.

1.40 The Patient Participation Group Chairs' Network is a valuable forum that challenges and scrutinises the CCG's commissioning programmes, ensuring there is patient engagement at practice level across the county. During 2017/18, the network has contributed to a number of key areas of work, including the Sustainability and Transformation Plan, increased access to primary care, the community car scheme, joint work with Healthwatch, reducing medicines wastage, procedures of limited clinical value, the digital roadmap, carers' issues, the Symphony initiative, the GP out of hours service, and the Health and Wellbeing Board.

1.41 The PPG Chairs' Network has maintained its formal links with CCG governance through its representatives on the Governing Body, Clinical Operations Group and Joint Committee, creating a useful feedback loop between the PPGs and the CCG.

1.42 The nine geographical Health Forum meetings were discontinued in August 2017 following a detailed review of their effectiveness and function. A commitment was made to expand the CCG's online engagement options in order to reach people who do not usually attend meetings or events, including young people, people in full-time employment, parents and carers, BME communities, and people who are not regular service users.

1.43 Other conduits used to communicate with and involve patients, carers and the wider public include:

- a weekly e-bulletin, summarising engagement opportunities, circulated to more than 300 community stakeholders
- strong relationships with voluntary organisations and 3rd sector networks, through whom community intelligence can be collected and information cascaded
- strategic use of patient feedback via Healthwatch and increased use of Healthwatch's statutory role as a health watchdog
- the use of individual patient or carer experiences to highlight learning and areas for improvement at CCG Governing Body and Patient Safety and Quality Assurance meetings

Engaging with Partners

1.44 Each year NHS England commissions a stakeholder survey of all CCGs, which forms part of its annual assurance process and is a key part of ensuring effective relationships are in place to support commissioning.

1.45 In 2017 Somerset CCG invited 113 stakeholders to respond to the survey, including Member Practices, the Local Authority, NHS Providers, Patient Groups and other organisations. A 73% response rate was achieved, which was higher than the national average of 62%. Overall, the survey described a positive picture of the CCG and its relationships. The results were generally comparable with 2016, showing improvements in a

number of areas and no significant areas of decline. The results also compared well with those in our CCG cluster, which is a group of 20 other CCGs with whom we are most similar taking into account population and index of multiple deprivation averages.

1.46 A Working Group was established to review the survey results and a number of recommendations were made for consideration alongside the Capacity and Capability Review. Rather than developing a separate action plan, the areas for improvement from the 360 survey were mapped into the recommendations for improvement from the Capacity and Capability Review. The findings have contributed to a significant organisational development plan which will be progressed during 2018.

Ensuring Staff Engagement within the CCG

1.47 Somerset CCG has invested a lot of energy into staff engagement over the past year. The CCG is committed to a culture where staff are given a voice and the ability to provide feedback on CCG work related matters. The past year has been a difficult one for the staff as the organisation faces a number of challenges. The CCG is now clear about the drivers for failure and are looking forward to working with staff to develop new ways of working, supported by a range of engagement opportunities.

1.48 A number of key engagement opportunities are in place for staff which are set out below.

Staff Forum

1.49 The Staff Forum consists of staff representatives from each Directorate across the organisation. This forum provides a platform for staff to raise anything in relation to their working lives within the CCG. The staff forum is an active group and gets involved in a number of projects such as:

- Staff Survey
- Staff Awards
- Briefing events
- Policies and procedures
- Change management

1.50 The Staff Forum sits under the Workforce Group which comprises of a Non-Executive Director, Directors, Senior Managers and a Staff Forum Representative and this group reports to the Remuneration Committee. Therefore the staff voice within the organisation is heard by senior leaders across the CCG.

Staff Suggestions

1.51 There are plenty of other opportunities for staff to share their views. We have a staff suggestion box where staff can make anonymous or named

comments about anything relating to their working life at the CCG. Suggestions are listened to and responded to.

Health and Wellbeing

1.52 A number of events are held for staff regarding their health and wellbeing such as Healthy Eating, Mindfulness and Self-Care Self-Aware. These events help to raise the level of staff engagement across the CCG by getting staff involved.

Support Networks

1.53 Band 7 members of staff have been invited to join a learning network. These learning and engagement events are facilitated and designed to provide a platform for staff to learn from each other through shared experiences, provide peer support, and also learning about their own styles and learning techniques. Events that are held are evaluated to ensure that feedback can be listened to and improvements can be made. The CCG established a Compassionate Network for staff. All members of staff at the CCG have access to a compassionate network where identified individuals provide support and guidance during times of difficulty.

1.54 In addition an Employee Assistance Programme is in place. The employee assistance programme allows staff to have confidential discussions regarding their work personal life. It facilitates good engagement with staff members by providing them with the opportunity to seek advice and guidance outside of the organisation which enhances their working life and experience.

Staff Non-Executive Director

1.55 We have a dedicated Non-Executive Director, Dr Jayne Chidgey-Clark, who is a staff champion and is involved with staff engagement across the CCG. She is also the CCG Raising Concerns champion.

Reducing Health Inequality

Equality and Diversity

1.56 The CCG works with partner agencies across Somerset to meet its statutory and regulatory duties in respect of equality, diversity and inclusion. This includes the Public Sector Equality Duty and the many regulatory tools, such as Workplace Race Equality Scheme, Equality Delivery System 2 (EDS2), and the Accessible Information System (AIS).

1.57 Key achievements in this work area in 2017/18 include:

- the implementation of Quality and Equality Impact Assessments (EIAs) within the CCG.

- provision of enhanced equality training for CCG staff to complement the mandatory training provided

- a review of the (EDS2) which was taken to the Governance Committee for approval and the report can be viewed on the CCG website

- working with the Somerset County Council, four of the District Councils, all three NHS Trusts, and other public sector bodies, the CCG is looking to create joint and shared equality objectives across the county

1.58 Key focus for 2018/19:

- promoting and supporting the use of EIAs in all of the CCG's activities

- increasing the level of participation from minority and seldom heard from groups

- improving the accessibility and representation of the CCG's public facing website

- maintaining regulatory and statutory compliance in respect of equality, diversity and inclusion

- implement county-wide equality objectives in line with other NHS bodies and public sector organisations

Joint Strategic Needs Assessment (JSNA)

1.59 The Joint Strategic Needs Assessment Summary for 2017 has a focus on ageing well. It looks at the health, social care and wellbeing needs of the population aged over 65 and is complemented by a qualitative report detailing personal experience and attitudes to ageing well. It is published at www.somersetintelligence.org.uk/jsna

1.60 The Health and Wellbeing Board approved the JSNA Summary and qualitative report on 13 July, 2017 and the CCG Governing Body undertook, at its meeting on 14 September 2017, to incorporate the findings in developing and undertaking commissioning intentions.

1.61 In summary the JSNA highlights that for Health and Social Care:

- 45% of disease burden, notably the long term conditions that tend to arise over life to affect older people (including dementia) can be prevented or delayed by lifestyle:

  - not smoking

- drinking responsibility
- good social contact
- eating well
- exercise

- there is no age after which improvements in lifestyle do not help improve health

- inequalities were very evident, with a disproportionate burden of ill health being borne by the most disadvantaged. Addressing inequalities will improve lives and save money within health and social care

- self-help and short-term help to regain independence after falls, for instance, were commended by participants

- family and community carers bring benefits to those being cared for, the wider health and care system, and, if not overburdened, to carers themselves

Commissioning Strategy for Health and Care

1.62 The Commissioning Strategy for Health and Care in Somerset will:

- improve the health and wellbeing of our local population and address health inequalities

- change the way services are commissioned and delivered in order to provide higher quality care and ensure their long term sustainability and affordability

1.63 We will do this by:

- looking at the current and the future needs of the local population
- the case for change in services
- what all the options for change are
- identify what we need to do in order to implement the changes we seek

1.64 The programme will be led by the Somerset County Council and the Somerset Clinical Commissioning Group and will have full involvement from:

- local people – whether as service users, patients, carers or as members of the public, who will help us “co-design” the services of the future

- local providers of health and social care, including the voluntary and third sector, as well as statutory organisation

Health and Wellbeing Strategy

Health and Wellbeing Board

1.65 The CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2018:

Member	Organisation
Cllr Christine Lawrence (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr David Huxtable	SCC
Cllr Linda Vijeh	SCC
Cllr Amanda Broom	SCC
Cllr Jane Warmington	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 (Vice Chair)	Somerset CCG
Dr Rosie Benneyworth	Somerset CCG
Nick Robinson	Somerset CCG
Mark Cooke	NHS England
Judith Goodchild	Healthwatch
Trudi Grant	Director of Public Health, SCC
Stephen Chandler	Director of Adult Social Services, SCC
Julian Wooster	Director of Children's Services, SCC

1.66 The Health and Wellbeing Board has an annual programme of work which addresses a number of key priorities which are informed by the Joint Strategic Needs Assessment and by evidence for effective action. During 2017/18 these priorities have been:

- to provide joint leadership for prevention across the county;
- to give system leadership to build strong, resilient and healthy communities, with a particular focus on ending loneliness;
- to drive and oversee new, integrated and sustainable models of care across the county, notably through Somerset Together and the STP
- to further develop work to improve identification and early intervention to prevent Hidden Harm of children;
- to identify and address the impacts of housing on health and wellbeing
- to increase use of licencing powers to promote health wellbeing and reduce harm

1.67 The Health and Wellbeing Board is the partnership which has oversight responsibility for the STP, and the Board have received regular reports, and have been consulted on developments.

Safeguarding Children and Young People

1.68 Section 11 of the Children Act 2004 places a legal duty on all health organisations to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. Requirements placed on the CCG, with regard to safeguarding and promoting the welfare of children, are further outlined in key national guidance and legislation detailed in full in Appendix 1. The guidance and legislation listed set out clearly the safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care, and affect how the CCG commission, manage and monitor services within Somerset.

Ofsted Inspection of Somerset County Council 2017

1.69 In 2017 Ofsted undertook an inspection of the local authority services for children who need help and protection, children looked after and achieving permanence, and Leadership, management and governance. The local authority was judged as Requires Improvement in January 2018, with the overall findings from this inspection demonstrating that the local authority has made steady progress in improving the quality of services that children and young people in Somerset receive.

1.70 Somerset CCG are working in partnership with the local authority and other agencies to address the recommendations identified in the Ofsted Inspection report that relate to all services, including the CCG, Primary Care Services and NHS providers commissioned by the CCG.

Serious Case Reviews

1.71 In accordance with the statutory guidance 'Working Together to Safeguard Children (2015), the decision to initiate a serious case review (SCR) is made by the Somerset Safeguarding Children Board, of which the CCG is an active member at a strategic and executive level. In 2017 there were two Somerset serious case reviews published:

- Child Sam: a six-month-old baby taken to a Minor Injury Unit in November 2015 by members of his family. He had suffered an extensive non-accidental head injury and went on to have surgery for at Bristol Children's Hospital. His injuries have left him with life-long impairments

- Fenestra Serious Case Review into Child Sexual Exploitation: A review of the way agencies responded to cases of Child Sexual Exploitation (CSE) in Somerset. It follows 'Operation Fenestra', an investigation into offences that took place between 2010 and 2014 and resulted in the conviction of two men for sexual offences against six victims aged between 14 and 15 and a seventh victim aged 18

1.72 The CCG incorporated lessons to be learned from these reviews into training days delivered to GP Safeguarding Leads. The CCG continue to

work in partnership with all agencies, including those we are lead commissioner for, to embed the learning into practice. In 2017 the decision to initiate the following reviews was made by the Somerset Safeguarding Children Board:

- a Serious Case Review (SCR)with a focus on child neglect
- a learning review with a focus on learning lessons from the way in which partners worked together to safeguard a child with disabilities.
- a thematic review with a focus on child suicides
- a thematic review with a focus on persons known or suspected to have committed child sexual offences that had access to children within their own families

1.73 These reviews are still in progress and the CCG is working in partnership with all agencies across Somerset to identify the learning from these reviews.

1.74 Future safeguarding children priorities for Somerset CCG include:

- working in partnership with regional representatives in the development of new multi-agency safeguarding children arrangements
- working in partnership with national leads in meeting the Statutory Health Needs of Looked After Children through a Standard Approach to Commissioning and Service Delivery
- working in partnership with local agencies to improve on systems and processes in place in Somerset for early help and safeguarding; including the robustness of early help and child protection referrals
- improvement on quality assurance arrangements in place for the services we are lead commissioner for; through the development of a safeguarding children data dashboard and a quality assurance programme
- maintaining robust oversight and scrutiny of all aspects of the health service contribution to safeguarding children across Somerset
- ensuring that the safeguarding children element of contracts are robust and clearly identify the commissioned service's responsibility in relation to safeguarding and promoting the welfare of children

Emergency Planning

1.75 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.

1.76 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 2017/18 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in Somerset. In addition, organisations across Somerset work closely together to ensure that plans are as integrated and effective as possible.

1.77 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. The CCG and the three providers were assessed as being substantially compliant.

1.78 Somerset responded to a severe weather major incident in March 2018 as a result of heavy snowfall across the county. All the partner organisations cooperated effectively to maintain services and implemented their respective emergency plans. Learning from the response to the incident will be shared and implemented during 2018/19 as part of the ongoing testing and exercising of plans.

Risk Management

1.79 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.

1.80 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.

Overview of Somerset CCG Strategic Risks

1.81 The CCG's strategic risks form an integral part of the Governing Body Assurance Framework (GBAF) which is reviewed regularly by the CCG. The latest version of the GBAF can be found by visiting the CCG's website and the pages for the Governing Body meetings. In 2017-2018

the CCG commenced a governance review, including a review of the GBAF. There is also more detailed analysis of the key risks set out in the Governance Statement later in this report.

Key risks managed by the CCG during this financial year have included:

- the CCG's financial budget overspends due to under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings targets or overspends against activity related contracts and national increases in drug tariffs
- ability to release cost improvement savings increase in demand arising from an aging population
- access to services waiting times, including waits in A&E and from referral to treatment
- the quality and safety of some services identified through CCG quality monitoring systems and / or through CQC regulatory inspections. In 2017/18 this was a particular concern for the 111 and Out of Hours GP Primary care service provided by Vocare in Somerset
- future sustainability of services at Weston Area Health NHS Trust
- workforce sustainability
- capability and capacity of the CCG to ensure focus on key priority areas to deliver required improvement and which has also led to a review of the CCG's governance arrangements

FINANCIAL AND PERFORMANCE ANALYSIS

Finances

1.82 NHS England has directed, under the National Health Service Act 2006 (as amended), that CCGs prepare financial statements in accordance with the 'Group Accounting Manual 2017/18 issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2017/18 financial statements.

Operating and Financial Performance

Financial Duties

1.83 During 2017/18, Somerset CCG performance against its financial duties is shown in the table below:

2017/18 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	✓

1.84 Specific details of each of these duties are provided below.

Overview

1.85 For the financial year 2017/18 (1 April 2017 to 31 March 2018), Somerset CCG delivered all of its financial targets and delivered a deficit of £540,000 against its in year resource limit of £736,572,000.

Analysis of Revenue Performance

	2017/18 £'000
In Year Revenue resource limit	736,572
Overspend against revenue resource limit	(540)
Percentage overspend against revenue resource limit	-0.07%

1.86 Somerset CCG planned to deliver an over spend of £1,748,000 for 2017/18 representing 0.2% of the total funding allocation, against the portfolio of services it commissions, as agreed with NHS England. The

position delivered was a deficit of £4,092,000 after enacting the system wide risk share and its relative benefit from the nationally held category M savings. The CCG has received confirmation from NHS England that for the purposes of the annual accounts, the CCG held headroom reserve (£3,552,000) should be shown against the CCG position, which results in a £540,000 deficit at the year end.

1.87 For assessing CCG performance against financial standards, the CCG is not able to apply the headroom reserve but a tolerance will be applied to take into account the significant unplanned cost of 'No Cheaper Stock Obtainable' (£3,089,000) offset by the benefit from the nationally held category M drugs (£745,000). This will result in the CCG being within the tolerance level of the planned control total of £1,748,000 set by NHS England for 2017/18.

1.88 The publication of 'Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21' signalled the importance for Clinical Commissioning Groups to work in partnership with the local system to have plans which are balanced, meet the business rules and are aligned across it's strategic, operational and financial measures.

1.89 This plan represents the second year of the emerging whole system Sustainability and Transformation Plan. The Financial Framework for 2017/18 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

1.90 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.

1.91 This financial strategy will put in place the resources required to deliver key elements of the strategy set out in the Sustainability and Transformation Plan, whilst continuing to improve performance against national targets. A theme of the strategy is to maintain flexibility to respond to the emerging pressures and issues.

1.92 During 2017/18, monthly financial reports were regularly presented to the Somerset CCG Governing Body highlighting the in-year performance and forecast year end outturn.

1.93 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 five meetings during the year and considered:

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

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

1.95 The following summary financial statements are an extract from the Somerset CCG's Annual Accounts for 2017/18, and describe how Somerset CCG used its resources to deliver health services to residents of Somerset during 2017/18. An explanation of the key financial terms can be found on pages 48-49.

1.96 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@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 2018

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

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,480)	(2,000)
Other operating income	2	(4,374)	(1,058)
Total operating income		**(6,854)**	**(3,058)**
Staff costs	4	9,147	7,454
Purchase of goods and services	5	734,029	721,065
Depreciation and impairment charges	5	88	78
Provision expense	5	225	358
Other Operating Expenditure	5	477	603
Total operating expenditure		**743,966**	**729,558**
Net Operating Expenditure		**737,112**	**726,500**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**737,112**	**726,500**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**737,112**	**726,500**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**737,112**	**726,500**

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

Going Concern

Introduction

1.99 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.

1.100 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.

1.101 The Department of Health Group Accounting Manual for 2017/18 has the following recommendation as the standard accounting policy:

The CCG's accounts have been prepared on a going concern basis. The Government Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 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. 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 must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate

- where an entity ceases to exist, it must 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

1.102 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

1.103 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.

1.104 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 approval of the accounts is considered appropriate.

1.105 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.

1.106 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

1.107 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 2017/18

Outturn

1.108 The financial outturn for 2017/18 is a deficit of £540,000 (-0.07%) against the control total agreed with NHS England of a deficit of £1.748m. This takes into account the enactment of the system wide risk share, the relative benefit from the nationally held category M savings, and the CCG held headroom reserve (£3,552,000). 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. For assessing CCG performance against financial standards, the CCG is not able to apply the headroom reserve but the assessment will take into account the significant unplanned cost of 'No Cheaper Stock Obtainable' (£3,089,000) offset by the benefit from the nationally held category M drugs (£745,000). This will result in the CCG achieving the planned control total of £1,748,000 set by NHS England for 2017/18 for assessment purposes.

Interim Operational Financial Plan 2018/19

1.109 The CCG Governing Body approved interim an financial plan for 2018/19 at its meeting on 22 March 2018.

1.110 The interim CCG plan does not comply with the CCG business rules, specifically it will not deliver a 1% cumulative surplus or deliver the surplus control total set for 2018/19. The system is working towards producing a 3 year Financial Recovery Plan to the NHSE deadlines confirmed in the planning guidance.

1.111 This interim plan reflects the current position for Somerset CCG, however this position is expected to improve in year through the delivery of the following complimentary workstreams and actions:

- implementation of the Sustainability and Transformation Plan turnaround initiatives
- managing risk and demand through the system wide Investment Pool
- in year application of any remaining contingency

1.112 The CCG has based its interim plan for 2018/19 on published notified allocation of £724.9m 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 - £11.8m
- Identification Rules Adjustment - £3.4m
- NHS Property Services market rent - £0.3m
- Additional Funding - £6.1m
- Primary Care Improving Access Funding - £3.3m
- Price Change Adjustment – (£4.9m)
- Paramedic Rebanding - £0.5m
- HSCN - £0.2m

The overall Revenue Resource Limit is therefore £745.65m.

1.113 Although the interim budgets contain a significant unresolved financial challenge to deliver the control total as set by NHS England, the CCG needs to ensure that through the actions detailed above, the CCG will not breach the CCG statutory duties as detailed in sections 223H(1) and 223I(3) of the NHS Act 2006 (as amended) which state the clinical commissioning groups have to:

- ensure expenditure in a financial year does not exceed income
- ensure revenue resource use does not exceed the amount specified in directions

1.114 Further updates to this plan will be presented to the Governing Body through the monthly finance report and will specifically highlight the progress against the challenge to achieve overall expenditure in line with the control total.

1.115 The financial plans for 2018/19 have been based on a number of planning assumptions, which have in turn been taken from national planning guidance and local decisions.

1.116 The interim plan sets aside investment monies for mental health, community services and primary care totalling £7.05m. There needs to be agreement on how this funding will be utilised in 2018/19 in order to maximise the benefits, including a reduction of emergency activity

1.117 The impact of the above is that the CCG faces a financial challenge of £22.7m in 2018/19. QIPP schemes include £5m against Continuing Health Care and £2.3m against GP Prescribing, however the plan does not include any demand management reductions at this stage, and once these have been agreed with system partners, these will be included for the further planning submission.

Cash Flow

1.118 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 2017/18 and is planning to do so on an ongoing basis.

Contingent Liabilities

1.119 The contingent liability in 2017/18 relates to Continuing Healthcare.

1.120 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

1.121 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.

Planning Assumptions

1.122 Acute growth has been moved to locally agreed growth levels however these remain subject to change as part of an ongoing review of the demand and capacity across Somerset. There is a risk that activity exceeds this or issues arise in year that have not been planned for.

1.123 As discussions regarding the Memorandum of Understanding supporting the local contract mechanism progress this pressure may move into the CCG's position. All other growth rates remain at previous 2017-19 STP/CCG plan levels.

1.124 Growth on mental health and community contracts has been included as an investment rather than growth, along with the additional investment required to meet the mental health investment standard, whilst discussions are ongoing across the Somerset system as to how this funding should be most appropriately deployed.

Quality, Innovation, Productivity and Prevention (QIPP) Schemes

1.125 As highlighted about the interim plan for 2018/19 QIPP schemes include £5m against Continuing Health Care and £2.3m against GP Prescribing, however the interim plan does not include any demand management reductions at this stage, and once these have been agreed with system partners, these will be included for the further planning submission.

Documentation

1.126 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.

1.127 The Finance Group of the CCG will continue to meet on a monthly basis to review the financial position and identify mitigating actions to ensure the CCG delivers the interim plan.

Recommendation

1.128 Having considered the position as set out above, it is recommended that management prepare the annual accounts for 2017/18 on a going concern basis.

Revenue Resource Limit

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

1.130 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.

1.131 The Somerset CCG performance for 2017/18 is as follows:

	2017/18 £'000
Total net operating cost for the financial year	737,112
Final in year revenue resource limit for the year	736,572
Under/(over) spend against revenue resource limit	**(540)**

1.132 This table highlights that, in 2017/18 Somerset CCG overspent by £540,000 representing 0.07% of the Somerset CCG's resource limit.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2018

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

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

	General fund £'000	**Revaluation reserve £'000**	**Other reserves £'000**	**Total reserves £'000**
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(29,839)	0	0	**(29,839)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(29,839)**	**0**	**0**	**(29,839)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(737,112)			(737,112)
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	**(737,112)**	**0**	**0**	**(737,112)**
Net funding	728,954	0	0	728,954
Balance at 31 March 2018	**(37,997)**	**0**	**0**	**(37,997)**

	General fund £'000	**Revaluation reserve £'000**	**Other reserves £'000**	**Total reserves £'000**
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(24,957)**	**0**	**0**	**(24,957)**
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 31 March 2017	**(24,957)**	**0**	**0**	**(24,957)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(726,500)			(726,500)
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	**(726,500)**	**0**	**0**	**(726,500)**
Net funding	721,618	0	0	721,618
Balance at 31 March 2017	**(29,839)**	**0**	**0**	**(29,839)**

1.134 This statement records the movements in reserves for the year ended 31 March 2018.

Statement of Financial Position as at 31 March 2018

1.135 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

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	321	370
Intangible assets	14	9	13
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		330	383
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	7,625	7,684
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	71	49
Total current assets		**7,698**	7,735
Non-current assets held for sale	21	0	0
Total current assets		**7,698**	7,735
Total assets		**8,028**	8,118
Current liabilities			
Trade and other payables	23	(45,303)	(37,178)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(722)	(779)
Total current liabilities		**(46,025)**	(37,957)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(37,997)**	(29,839)
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		**(37,997)**	(29,839)
Financed by Taxpayers' Equity			
General fund		(37,997)	(29,839)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(37,997)**	(29,839)

1.136 This statement records the assets and liabilities of Somerset CCG as at 31 March 2018.

Statement of Cash Flows for the Year Ended 31 March 2018

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

Statement of Cash Flows for the year ended 31 March 2018

	Note	**2017-18 £'000**	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(737,112)	(726,500)
Depreciation and amortisation	5	88	78
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	0
(Increase)/decrease in trade & other receivables	17	59	(2,197)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	8,125	7,433
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(282)	(489)
Increase/(decrease) in provisions	30	225	358
Net Cash Inflow (Outflow) from Operating Activities		**(728,897)**	(721,317)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(35)	(302)
(Payments) for intangible assets		0	0
(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		**(35)**	(302)

Net Cash Inflow (Outflow) before Financing		**(728,932)**	(721,619)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		728,954	721,618
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		**728,954**	721,618
Net Increase (Decrease) in Cash & Cash Equivalents	20	**22**	(1)
Cash & Cash Equivalents at the Beginning of the Financial Year		**49**	50
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		**71**	49

1.138 This statement records the movement in cash between 1 April 2017 and 31 March 2018. For 2017/18, the Somerset CCG's cash balance was £71,234.

Better Payment Practice Code

1.139 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.

1.140 The Somerset CCG's performance for the year ended 31 March 2018 is summarised below:

Measure of compliance	2017-18 Number	2017-18 £000	2016-17 Number	2016-17 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**12,272**	**124,745**	**20,076**	**124,357**
Total Non-NHS Trade Invoices paid within target	**12,248**	**124,265**	**20,026**	**124,242**
Percentage of Non-NHS Trade invoices paid within target	**99.80%**	**99.62%**	**99.75%**	**99.91%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,396**	**512,129**	**3,617**	**499,887**
Total NHS Trade Invoices Paid within target	**3,387**	**511,760**	**3,604**	**499,860**
Percentage of NHS Trade Invoices paid within target	**99.73%**	**99.93%**	**99.64%**	**99.99%**

1.141 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

1.142 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 ££728,954,136.64 (99.5%) against a cash limit of £732,538,333.67 meeting this requirement.

Running Costs

1.143 The CCG was funded £11.882 million, equating to £20.67 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 £3,836,414 which covers Commissioning Delivery Support, Organisational Support, Referral and Booking Management Service and GP IT Services. Expenditure recorded against running costs for 2017/18 totalled £10.992 million.

Accounting Policies

1.144 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

1.145 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

1.146 The Grant Thornton UK LLP is the appointed external auditor for the Somerset CCG. The total fee paid to Grant Thornton UK LLP in 2017/18 was £63,000 including VAT to cover the cost of the statutory audit and associated services.

Governance Statement

1.147 The Chief Officer, 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.

1.148 A copy of the full Governance Statement is included in section 2.15 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

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 flows	A summary of the cash paid and received by the Clinical 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 position	Summarises the financial position of the Clinical Commissioning 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

Performance Summary

1.149 NHS England assesses Somerset Clinical Commissioning Group's performance against the CCG Improvement and Assurance Framework on an ongoing basis, resulting in an overall performance rating at the end of the year. There are four domains to the framework with four rating categories: outstanding, good, requires improvement and inadequate. In 2016/17 Somerset CCG was assessed as inadequate.

1.150 Performance against the key NHS Constitution requirements has continued to be closely monitored with service providers through the formal monthly contract and access and performance group meetings and where performance has not met the national standard remedial action plans and improvement trajectories have been agreed.

1.151 2017/18 was a challenging year where providers struggled to consistently meet the Accident and Emergency operational standard whereby 95% of patients should be seen, diagnosed, discharged or admitted within four hours of arrival. Despite this there have been zero 12 hour trolley waits and a notable improvement in the number of ambulance handover delays during Q4 2017/18.

1.152 Performance against the Referral to Treatment (RTT) local operating framework Incomplete Pathway trajectory, which was set lower than the national 92% incomplete pathway standard, has been delivered throughout 2017/18. Whilst Yeovil District Hospital NHS Foundation Trust recovered the national standard in January 2017 delivered sustained operational compliance during 2017/18, Taunton and Somerset NHS Foundation Trust continued not to deliver this standard.

1.153 Performance against the diagnostic waiting times standard has deteriorated during 2017-18. Cumulatively 94.3% of patients waited less than six weeks for a diagnostic test or procedure against the 99% standard and is underpinned by an increase in radiology and endoscopy modality breaches at Taunton and Somerset NHS Foundation Trust.

1.154 Somerset Clinical Commissioning Group achieved five of the nine cancer standards in 2017/18, under achieving the 2 week suspected cancer, 2 week breast symptom standards, and 62 day (from GP referral and consultant upgrade) waiting time cancer standards.

Performance Analysis

1.155 Somerset Clinical Commissioning Group has strong governance arrangements in place to enable us to hold our health services providers to account. In our role as lead commissioner of a provider we hold regular formal meetings in order to review latest performance ensuring that any emerging issues are reported, discussed and challenged. These meetings are minuted with the progress against actions agreed and monitored. If the CCG are not fully assured with the level of performance action can be taken including requesting action plans with target dates for improvements and issuing contract query notices.

1.156 As part of the 5 Year Forward View, during 2016-17 The Sustainability and Transformation Fund (STF) was introduced, in order to provide the NHS with the resources it needs to sustain services. Both Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust agreed to a financial control total and as a result were not liable for penalties in a number of key areas including A&E four hour, RTT Incomplete Pathway, Diagnostics and Cancer 62 day waiting time standards (and other associated measures such as 52 week wait, ambulance handover and trolley breaches). All incident based penalties continue to attract penalties.

1.157 Normal penalty arrangements continue to apply to Shepton Mallet Treatment Centre and Nuffield Taunton, who are not subject to the STF conditions.

1.158 The performance delivered in respect of emergency and urgent care during the reporting period 1 April 2017 to 31 March 2018, for Somerset residents is set out below:

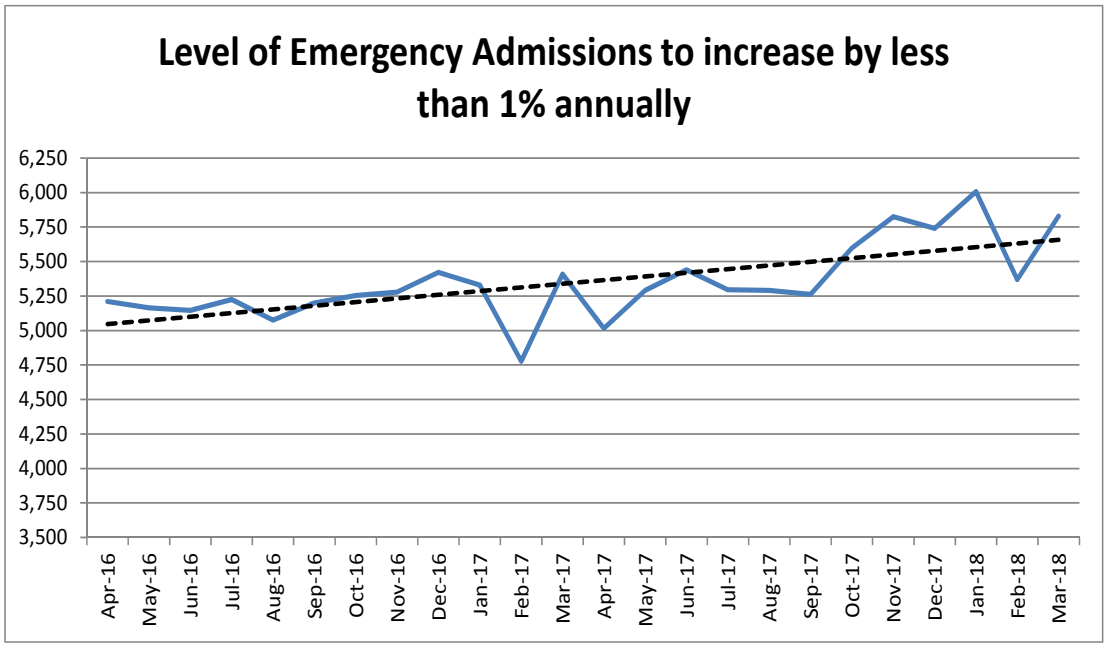
Emergency and Urgent Care Performance Scorecard between 1 April 2017 and 31 March 2018

Emergency Care	Standard	YTD 17/18	Variance +/(-)
Cumulative percentage of Trustwide MPH & YDH patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95%	93.37%	(1.63%)
Cumulative percentage of Somerset CCG patients spending no more than four hours in A&E from arrival to admission, transfer or discharge (inclusive of MIU activity)	95%	94.66%	(0.34%)
Percentage of ambulance handovers to A&E department within 30 minutes	100%	94.00%	(6.00%)
Percentage of ambulance handovers to A&E department occurring between 30-60 minutes	0%	5.66%	5.66%
Percentage of ambulance handovers to A&E department over 60 minutes	0%	0.34%	0.34%
Level of emergency admissions to increase by less than 1% annually	1%	5.57%	4.57%
Operations cancelled at the last minute offered another admission date within 28 days	100%	92.76%	(7.24%)
Percentage of people admitted to a stroke unit within 4 hours of hospital arrival	80%	66.58%	(13.42%)

1.159 Performance against the A&E operational standard whereby patients should spend no more than four hours in A&E from arrival to admission, transfer or discharge has been variable during 2017/18. Whilst Yeovil District Hospital is placed in the top 10 of highest Acute performing Trusts nationally during 2017/18 despite seeing a 8.0% increase in attendance, the performance at Taunton and Somerset NHS Foundation Trust has been more challenged. Taunton and Somerset NHS Foundation Trust has experienced a 10.2% increase in attendance (particularly in the out of hours period) resulting in a decline in performance; alongside this Trust also seen an increase the in the number of ambulance arrivals. However despite the decline in A&E four hour performance, specifically over the winter period, there has been an improvement in ambulance handover performance as a result of South Western Ambulance Service NHS Foundation Trust undertaking a review of ambulance handover times in the context in the change in ambulance crew shift patterns.

1.160 As part of the national roll-out programme, both local Providers implemented their Integrated Front-door Streaming (GP Streaming) in order to improve patient flow.

1.161 The number of emergency admissions has increased by 5.6%, and represents deterioration upon the growth seen in the previous year with a significant increase in admissions over the winter period. The most significant area of growth at Taunton and Somerset NHS Foundation Trust is within the older person age group who have a length of stay greater than one day. Conversely the most significant area of growth at Yeovil District Hospital NHS Group is an increase in the number of patients with a zero length of stay, which is attributed to the expansion of the Ambulatory Emergency Service and the South Somerset Symphony service.



1.162 A number of opportunities to reduce the number of emergency admissions and consumed bed days have been identified by RightCare. Within the falls and fractures, circulatory, COPD, and medically unexplained symptom work streams a number of pathway changes have been identified during 2017/18 include reducing the length of stay for specific procedures, early mobilisation post procedure and improving the discharge and transfer process as well as a number of focused primary care actions. The CCG is working with Providers as they implement the required changes in order to realise these opportunities and improve operational performance in 2018/19.

Ambulance Response Times

Percentage of Category A calls receiving a response from South Western Ambulance Service NHS Foundation Trust for the period 1 December 2017 to 31 March 2018

Standard	Target	Trust-wide Performance	Performance in Somerset
Category 1 response - mean	7 mins	9.6	10.2
Category 1 response - 90th percentile	15 mins	17.5	18.8
Category 2 response - mean	18 mins	33.6	37.5
Category 2 response - 90th percentile	40 mins	69.9	75.8

1.163 The way South Western Ambulance Service NHS Foundation Trust are measuring their Category 1 response times changed on 23 November 2017 in line with the new national Ambulance Response Programme (ARP) standards. These new ARP standards were introduced in order to

improve response times to critically ill patients through more appropriate use of triage time.

1.164 During the period December 2017 to March 2018 on a cumulative basis the mean Category 1 (life threatening calls) performance was 10.2 minutes against the 7 minute national standard compared against Trust-wide performance of 9.6 minutes; nationally only 1 Ambulance Trust is meeting this new standard and national review of the ARP standards is due to take place in the spring.

Waiting Times for Cancer Treatment

1.165 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

1.166 The performance scorecard in respect of the cancer waiting times standards achieved for services and Somerset patients, for the period 1 April 2017 to 31 March 2018 is shown below.

Waiting Times Standard	Standard	YTD 17/18	Variance +/(-)
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	92.90%	(0.10%)
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	91.27%	(1.73%)
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	97.09%	1.09%
31-Day Standard for Subsequent Cancer Treatments-Surgery	94%	94.92%	0.92%
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98%	99.77%	1.77%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	96.69%	2.69%
62 day wait - % treated in 62 days from GP referral	85%	80.14%	(4.86%)
62 day wait - % treated in 62 days from screening programme	90%	94.73%	4.73%
62 day wait - % treated in 62 days from consultant upgrade	90%	85.80%	(4.20%)

1.167 The NHS Constitution includes a number of targets relating to treatment for cancer patients. These include the right to be seen within two weeks when referred for a suspected cancer; the right to be treated within 62 days from the date of GP referral to treatment; and the right to be treated within 31 days from the day of decision to treat to the day of treatment.

1.168 During the period April 2017 to March 2018 five of the nine standards were delivered for Somerset patients; the standards not met include the 2 week suspected cancer and 62 day operational standards. The factors influencing performance include an increase in the number of suspected cancer referrals, an increase in the number of complex cases with patients often requiring multiple diagnostic tests prior to diagnosis and the number of patients requiring treatment outside of Somerset. Both local Providers have 62 Day Cancer Improvement Plans in place in order to improve and sustain 62 day cancer performance.

Referral to Treatment Pathways

1.169 The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2017 to 31 March 2018 is set out below.

Somerset Clinical Commissioning Group Key Performance Scorecard (Somerset Relevant Population) between 1 April 2017 and 31 March 2018

Indicator		Standard	YTD 17/18	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%	87.99%	(4.01%)
	Average Median waiting time (2017-18)	7.2 Weeks	7.3	0.1 Weeks
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99%	94.28%	(4.72%)

Referral to Treatment - Standards

1.170 The NHS Constitution stipulates that 92% of patients referred for NHS consultant-led treatment should wait no longer than 18 weeks from referral to definitive treatment, unless clinically appropriate or at the patients discretion. Whilst Yeovil District Hospital NHS Foundation Trust recovered the national standard in January 2017 and with the exception of March 2018 delivered sustained operational compliance during 2017/18, Taunton and Somerset NHS Foundation Trust continued not to deliver this standard. The performance at both local Providers declined over the winter period as a consequence of reduced elective flows with capacity further impacted as a result of operational pressures and the adverse weather resulting in an increase in patient cancellations. This has led to an increase in the number of patients awaiting treatment including those waiting over 18 weeks. Taunton and Somerset NHS Foundation Trust have an RTT specialty level, improvement plan in place which is tracked on a weekly and monthly basis.

1.171 Somerset Clinical Commissioning Group continues to monitor progress against improvement plans and is working with all Providers to improve performance during 2018/19.

Diagnostic Waiting Times - Standards

1.172 The NHS Constitution standard for diagnostics is that 99% of patients should wait less than six weeks for diagnostic test or procedure and on a cumulative basis during 2017/18, 94.3% of patient on the waiting list had been waiting six weeks or less. Performance has deteriorated during 2017/18 as a consequence of under-performance predominantly at Taunton and Somerset NHS Foundation Trust. Whilst the Trust successfully recovered audiology service waiting times performance in 2016/17 and sustained this in 2017/18 there has been a significant increase in the number of radiology and endoscopy patients breaching the waiting times standard. The Trust has ongoing capacity challenges within two radiology modalities (MRI and CT) and two Endoscopy (colonoscopy and gastroscopy) modalities which are underpinned by an increase in

demand (routine and cancer) further compounded by workforce constraints. The Trust continues to strengthen the workforce, identify and secure additional capacity and implement internal efficiencies in order to improve performance.

1.173 The CCG developed a DEXA Scan policy during 2017/18, which was produced following NICE guidance, which is being implemented and a Non-Obstetric Ultrasound policy has recently been agreed and awaiting implementation.

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: Nick Robinson

Nick Robinson
Accountable Officer
Somerset Clinical Commissioning Group

Date: 24 May 2018

2 ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

2.1 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.

2.2 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.

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

Statement of Disclosure to Auditors

2.4 Each individual who is a member of the CCG Members' Report, confirmed at the Governing Body of 24 May 2018, the following:

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

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

Modern Slavery Act

2.5 NHS Somerset Clinical Commissioning Group fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2017 is published on our website at http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/modern-slavery/

2.6 Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. When we hear the term modern slavery, most people think this only exists overseas, but the Home Office estimates there are 13,000 victims and

survivors of modern slavery in the UK. Modern slavery victims are among the most vulnerable people in our society and can be hesitant to seek help due to fear of their traffickers. Although modern slavery is considered a 'hidden' crime, many victims can be working or otherwise visible in the community, in a range of places such as nail bars, food outlets, car washes, factories, and the fishing industry.

2.7 With more than one million people accessing NHS funded services every 36 hours, the 1.5million staff that work in our NHS, not just in hospitals but in places where people live their lives, will come into contact with victims or survivors of modern slavery.

2.8 The CCG, along with partner agencies, is working towards a world without slavery by supporting, influencing and raising awareness:

- by supporting survivors and vulnerable people through the specialist services that we commission, we can enable them to recover safely and develop resilient, independent lives

- by influencing the development of the NHS workforce through access to national training, advice and resources we can better identify and support actual and potential victims of slavery

- by raising awareness of modern slavery through the CCG website and the safeguarding newsletter, we can support NHS staff to recognise the signs of modern slavery and understand the role they have to play

Table xx: Breakdown of CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 2018

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								
Nick Robinson	Chief Officer	✓	✓			✓		✓
Alison Henly	Chief Finance Officer and Director of Performance	✓	✓			✓	✓	
Sandra Corry	Director of Quality and Safety	✓	✓			✓	✓	
Dr Rosie Benneyworth	Director of Strategic Clinical Services Transformation	✓	✓				✓	✓
Paul Goodwin	Deputy Chief Officer and Director of Commissioning and Governance	✓	✓			✓	✓	
GP Practice Clinical Leadership								
Dr Ed Ford	CCG Chairman and GP Locality Delegate, West Somerset	✓	✓			✓		✓
Dr Amelia Randle	GP Locality Delegate, West and Central Mendip		✓				✓	
Dr Steve Edgar/ Dr Ian Wyer	GP Locality Delegate, South Somerset (job share)		✓					
Dr Alex Murray	COG Chair and GP Locality Delegate, Bridgwater Bay	✓	✓			✓		
Dr Helen Kingston	GP Locality Delegate, East Mendip		✓					
Dr Joey McHugh	Clinical Operations Group Vice Chair and GP Locality Delegate, North Sedgemoor		✓					
Dr Kate Staveley	GP Locality Delegate, CLICK		✓				✓	
Dr Will	GP Locality Delegate, Taunton		✓					

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
Chandler	Deane							
Trudi Mann	Practice Manager		✓					
Non-Executive Leadership								
Lou Evans	Vice Chair and Non-Executive Director (Lay Member - Governance and Audit)	✓		✓	✓	✓	✓	
David Bell	Non-Executive Director and Chair of the Joint Committee (Lay Member - Primary Care)	✓		✓	✓		✓	
David Heath	Non-Executive Director (Lay Member - Patient and Public Involvement)	✓			✓	✓	✓	
Dr Basil Fozard	Non-Executive Director (Secondary Care Specialist Doctor)	✓			✓	✓	✓	
Dr Jayne Chidgey-Clarke	Non-Executive Director (Registered Nurse)	✓		✓	✓	✓	✓	
Dr Trudi Grant	Director of Public Health, Somerset County Council	✓						✓

Statement of Accountable Officer's Responsibilities

2.9 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). I have been appointed by NHS England as the Chief Officer, to be the Accountable Officer of NHS Somerset Clinical Commissioning Group.

2.10 The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable
- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction)
- for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities)
- the relevant responsibilities of accounting officers under Managing Public Money
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended))
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended)

2.11 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.

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

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

- make judgements and estimates on a reasonable basis

- state whether applicable accounting standards as set out in the Group Accounting Manual issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements

- prepare the financial statements on a going concern basis

2.13 To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter, with the exception of the breach of financial duties under Sections 223H and 223I. This was due to Clinical Commissioning Groups' expenditure exceeding income, exceeding its resource limit by £540,000.

2.14 I also confirm that:

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

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

Signed: Nick Robinson

Nick Robinson

Accountable Officer

Somerset Clinical Commissioning Group

Date: 24 May 2018

Governance Statement

Introduction and Context

2.15 The NHS Somerset Clinical Commissioning Group (CCG) is a body corporate established by NHS England on 1 April 2013 under the National Health Service Act 2006 (as amended).

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

2.17 As at 1 April 2017, the CCG is subject to directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 as follows:

In July 2017 the CCG was given a performance rating by NHS England as 'inadequate' and was place in a reframed CCG special measures regime. Key areas to the failure of the CCG were:

- Insufficient progress was made against leading the financial recovery for the CCG and for the Somerset health system.
- Although the CCG had made good progress in many of the better care domains rising patient demand and failure of some key performance measure remained.
- System leadership was not optimal and collaborative system working did not support or improve our underlying deficit and performance issues.

Scope of Responsibility

2.18 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 under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

2.19 I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance Arrangements and Effectiveness

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

2.21 Somerset CCG is a membership body comprising of 70 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 Commissioning Locality is represented by one delegate on the Clinical Operations Group (COG) which in turn nominates its membership to the Governing Body.

2.22 Somerset CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: 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.

2.23 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.

2.24 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)

2.25 The remit of each committee is as follows:

Committee	**Key roles and responsibilities**
Clinical Operations Group (COG)	GP Clinical Lead: Dr Alex Murray Executive Lead: Nick Robinson 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. This includes the strategic development of priority programmes • 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 • considering the development of primary care and discussing the implications of commissioning decisions which relate to member practices as providers of healthcare (but recognising that contractual and financial decision-making around these would be managed by the CCG's Governing Body or Joint Committee as appropriate).
Audit Committee	GP Clinical Lead: Dr Geoff Sharp Executive Lead: Alison Henly 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 and counter fraud 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 and ensure robust action plans are in place, and delivered, to address any areas of weakness • the Audit Committee shall review the Annual Report and Financial Statements before submission to the Governing Body • 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	GP Clinical Lead: Dr Ed Ford Executive Lead: Paul Goodwin 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	GP Clinical Lead: Dr Ed Ford Executive Lead: Nick Robinson 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.
Joint Committee (Primary Care)	GP Clinical Lead: Dr Ed Ford Executive Lead: Paul Goodwin/Alison Henly (wef 8/3/18) The Joint Committee has delegated powers of responsibility from the Governing Body to commission primary medical services and has 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 workplan • oversee implementation of the CCG statutory duty to improve the quality of primary care

2.26 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. The 360 stakeholder survey 2016/17 highlighted a number of areas for improvement, including:

- patient and public engagement
- leadership
- stakeholder relationships

2.27 Since the results were published last year the CCG has undertaken an independent capacity and capability review and has also been participating in a newly framed special measures regime which has prompted the new Commissioning Capability Programme led by NHS England. There has also been a considerable programme of work to address the issues identified by the survey, review and other feedback.

2.28 In order to improve patient and public engagement we have:

- discontinued our geographical health forums following a review that indicated they were not offering us effective public engagement conduits
- proposed a number of online engagement options with the intention to engage a wider range of people and cohorts in our communities, including younger people, people in full-time employment, carers, families, black and minority ethnic communities and those who do not use health services regularly
- sought to widen participation in existing engagement conduits, including the Somerset Engagement Advisory Group, PPGs, Healthwatch and voluntary sector initiatives

- worked with NHS England to identify areas for corporate improvement and to run a bespoke workshop on participation for Somerset CCG staff and our key partners
- sought to roll out tailored training on public engagement for the CCG's Governing Body
- supported the new Healthwatch provider and connected Healthwatch to the CCG's non-executive director to raise the profile of patient voices at leadership level
- regularly presented patient and carer experiences to the CCG's Governing Body and Patient Safety and Quality Assurance Committee to highlight learning points and areas for improvement
- continued to develop relationships with voluntary and community sector partners who can support and add value to our public engagement efforts, including Village and Carer Agents, social care users' group, League of Friends, parent carer networks, Carers' Voice, mental health hubs and Community Ambassadors
- commenced joint work across the health and social care system as part of the Somerset Academy initiative
- undertaken early joint planning with Somerset County Council in preparation for public engagement and co-production as part of the Health and Care Strategy
- continued to work in partnership with Public Health on public engagement for the Health and Wellbeing Strategy

2.29 In terms of CCG leadership the CCG has embarked on many areas to improve confidence in leadership:

- new Chief Officer and changes at Executive level
- revisions to Directors and their portfolios
- embarking on an overall Organisational Development Programme
- review of the role of the GP within the CCG, to ensure clarity of role, clinical insight and experience in CCG business to support delivery of CCG priorities
- Governance review to improve decision making processes and ensuring more focus on quality in decision making including development sessions with the Governing Body and Leadership Team to review their effectiveness
- Health and Care Strategy and financial turnaround plan development

2.30 In terms of improving Stakeholder relationships:

- now working more closely with colleagues through the STP and the establishment of a system leadership group which includes Chairs and Chief Executives
- development of a Health and Care Strategy working alongside the Local Authority
- considering revisions to the locality/GP membership model to enable more closer working with practices

2.31 The Internal Audit work programme has been reviewed via the Audit Committee and this work supports our review of internal control 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.

UK Corporate Governance Code

2.32 The CCG are not required to comply with the UK Code of Corporate Governance. However, the CCG 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. For the financial year ended 31 March 2018, 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.

Discharge of Statutory Functions

2.33 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 will be further updated during 2017/18 with appropriate legal advice and approval by NHS England to reflect any changes to the organisational structure and responsibilities.

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

2.35 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.

Risk Management Arrangements and Effectiveness

The Clinical Commissioning Group Risk Management Framework

2.36 There is a clear commitment to corporate governance across the CCG and risk analysis and management are applied throughout the organisation.

2.37 The Somerset CCG Risk Management Strategy and Policy sets out the leadership and arrangements for risks management across the CCG.. 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. At the time of this annual report the CCG's governance arrangements are under review. In line with this which includes review of the CCG's committees and their delegated functions. A new committee structure will commence in April 2018. The policy will be updated to reflect any changes following completion of the review.

2.38 During 2017/18 the Governing Body recognised its Assurance Framework requires a review and refresh to reflect shifts in the CCG's priorities within this year in relation to:

- Turnaround
- Clinical Services Review
- Business as Usual

2.39 The Governing Body conducted a workshop on 22 March 2018 to review its priorities for inclusion in the Assurance Framework.

2.40 The CCG anticipate the development of a revised Assurance Framework will provide a foundation for the development of a Somerset health and care system wide approach to governance and risk management. This will need to incorporate:

- a system wide focus on performance standards to provide assurance for the Somerset health and care system and its leaders.

- be underpinned by the NHSE Improvement and Assessment Framework (IAF)

2.41 "The IAF aligns with NHS England's Mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.

2.42 The framework is intended as a focal point for joint work and support between NHS England and CCGs. It draws together the NHS Constitution, performance and finance metrics and transformational challenges and plays an important part in the delivery of the Five Year Forward View." https://www.england.nhs.uk/wp-content/uploads/2017/11/ccg-improvement-and-assessment-framework-2017-18.pdf

Capacity to Handle Risk

2.43 All CCG staff undertake training in the CCG's risk management arrangements as part of their induction training. This is supported by the CCG's risk management team, who provide senior managers and their staff with individual support when new risks are identified, recorded, assessed and reviewed on a quarterly basis.

2.44 The responsibility for any risks identified has a named Executive Director, including any actions required to mitigate the risk. The Governing Body regularly reviews the corporate risk register and associated action plans to ensure risks are being mitigated to reduce the impact for the patient population of Somerset.

2.45 Each committee reports to the Governing Body on a regular basis, to provide an update on the previous meeting and highlight any areas of risk which are being addressed.

2.46 The committees work programmes are based on a risk assessed approach, which aligns to the CCG priorities.

2.47 The Audit Committee undertakes an annual assessment against the Healthcare Financial Management Association's Audit Committee Handbook to ensure it has a robust focus over the next 12 months.

Risk Appetite

2.48 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.

2.49 The risk threshold for significant risks is defined by a risk rating of 12, and risks of 12 and above are included in the corporate risk register and 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.

2.50 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.

Risk Assessment

2.51 The CCG maintains its risk registers in an electronic computer database system. Directorate risk registers are populated and updated on an on-going basis. In practice the quarterly extraction and review of corporate risks (those scoring 12 and above) tends to drive a significant proportion of the on-going risk review activity across the CCG. Risk entries to are summarised to describe the risk in a manner which is accessible to the public and includes an appropriate action plan for further mitigation in accordance with SMART action plan principles.

2.52 In December 2017 the CCG's internal auditors carried out an assessment of the CCG's risk management arrangements. The purpose of the review was to complete a risk maturity assessment is to help ensure an effective risk management culture becomes embedded across the Clinical Commissioning Group, by highlighting areas where processes could be improved. Primarily this was an advisory piece of work and not to generate an assurance opinion.

2.53 The audit outcomes conferred the following ratings to the CCGs arrangements:

	Risk Governance	**Risk Assessment**	**Risk Mitigation**	**Monitoring and Reporting**	**Continuous Improvement**
Current	Defined	Defined	Managed	Managed	Defined
Target	Managed	Managed	Enabled	Managed	Managed

2.54 Recommendations were raised against each of the areas of the risk maturity assessment. An action plan has been developed and will be progressed during 2018/19 alongside the CCG's governance review process.

2.55 Key risks managed by the CCG during this financial year have included:

- the CCG's financial budget overspends due to under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings targets, overspends against activity related contracts and national increases in drug tariffs
- increase in demand arising from an aging population
- access to services waiting times, including waits in A&E and from referral to treatment
- the quality and safety of some services identified through CCG quality monitoring systems and / or through CQC regulatory inspections. In 2017/18 this was a particular concern for the 111 and Out of Hours GP Primary care service provided by Vocare in Somerset
- future sustainability of services at Weston Area Health NHS Trust
- workforce sustainability
- capability and capacity of the CCG to ensure focus on key priority areas to deliver required improvement and which has also led to a review of the CCG's governance arrangements

Other Sources of Assurance

Systems of Internal Control

2.56 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.

2.57 The CCG has an Equality and Equity 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 organisation 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.

2.58 The CCG has a Patient and Public Engagement Strategy for 2016-2020 in place that was approved by the Governing Body in March 2016. There is a strong engagement network in place in Somerset 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 Sustainability and Transformation Plan (STP).

The Clinical Commissioning Group Internal Control Framework

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

2.60 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.

2.61 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. During 2017/18 the CCG committee structure has be revised following the Capability and Capacity review, which was completed in the early part of 2017.

2.62 During 2017/18, the CCG Governing Body agreed to undertake a fundamental review of its strategy and have commenced a Health and Care Strategy review as part of the STP development. 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.

2.63 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 2017/18.

2.64 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

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

Annual Audit of Conflicts of Interest Management

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

2.67 An annual audit was carried out by the CCG's Internal Auditors which provided a moderate level of assurance of both the design and operational effectiveness of the CCG's systems for managing conflicts of interest.

2.68 Overall, the report raised eleven recommendations relating to the CCG's management of conflicts of interests, including nine medium level and two low level recommendation. The review found that there is room for improving the CCG's controls for the management of conflicts of interest but with no significant areas of concern, and there were not any major instances of non-compliance with the current controls, leading to a final assessment of moderate assurance over the control design, and moderate assurance over the control effectiveness. Each of the recommendations will be implemented in 2018/19.

Data Security

2.69 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. Somerset CCG reported two incidents assessed as Level 2 IG SIRIs during 2017/18. One concerned a Patient Transport Service dashboard disclosed to intended recipients later found to contain fields regarded as identifiable information. The second related to the Living Better service and a patient dataset shared with an intended recipient, but containing data relating to all Somerset Living Better patients rather than the patient cohort relevant to the specific group of GP practices making the request.

Data Quality

2.70 The CCG has continued to develop data quality in conjunction with the CSU during the 2017/18 financial year.

Information Governance

2.71 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 clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

2.73 Over 95% of all staff had completed their information governance training by 31 March 2018.

2.74 Somerset CCG has submitted a satisfactory level of with the Information Governance (IG) Toolkit with an overall compliance rate of 79% for 2017/18 which is unchanged from 79% in 2016/17. The clinical commissioning group has no requirements assessed as Level 0 or Level 1, sixteen at Level 2, ten at Level 3 and two 'Not Relevant'. Two requirements previously assessed as not relevant were determined relevant to Somerset CCG in 2017/18. These cover processing outside of the UK complying with the Data Protection Act and Department of Health guidelines and consistent and comprehensive use of the NHS number in

line with National Patient Safety Agency requirements. Particular improvement to Level 3 status was made in relation to user access rights to systems. All other Level 3 requirements were maintained with the exception of the requirement covering pseudonymisation and anonymisation techniques, as no external audit was carried out in year which is a requirement to maintain level 3. The level of compliance reflects the continued progress building upon the information governance structures and processes established when the CCG was established and provides a robust assessment of the progress to date.

2.75 2018/19 sees the introduction of the Data Security and Protection (DSP) Toolkit which replaces the IG Toolkit. A plan is in place to ensure that the work is undertaken and that compliance with the new DSP Toolkit will be achieved for 2018/19. This will be monitored through the Information Governance, Records Management and Caldicott Committee.

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

Business Critical Models

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

Equality, Diversity and Human Rights Obligations

2.78 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.

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

Third Party Assurances

2.80 Somerset CCG contracts with a range of third party providers in order to deliver both healthcare services to the population of Somerset and to support the corporate functions of the CCG, for example through the commissioning support service (CSU) and external pay-roll services.

Healthcare Services

2.81 Healthcare services are contracted through the standard NHSE Contract arrangements defined by NHSE England. Assurances for contract

performance and clinical quality and safety of the delivery of healthcare services commissioned by Somerset CCG are collected and reviewed through quarterly meetings and a range of assurance visits to walk the pathway or specifically review a service regarding the quality, safety and performance of healthcare delivered to patients. Providers are required to provide a wide range of information and metrics to demonstrate performance against their contracts. This information is triangulated and checked through a range of independent verification mechanisms, including:

- direct access to nationally published data submitted from and about commissioned services, such as Hospital Episode Statistics (HES), mortality data (SHMI and HSMR) National Patient Surveys and the Friends and Family test

- patient and public feedback through NHS Choices reviews, and local patient and public engagement including through HealthWatch Somerset. Complaints ,compliments and patient stories also provide a rich source of information regarding patient and carers experience of local services

- professional feedback from our GP membership through the GGC's Healthcare Professional Feedback system

- announced and where appropriate unannounced quality and safety assurance visits to services by the CCGs commissioning officers. On a number of occasions participation of key stakeholder's such as Education and Local Authority has been proactively sought to compliment such assurance visits

- collaborative working arrangements between the CCG as commissioners and our service providers in key areas of activity relation to quality and safety, such as the Somerset Complaints Managers Group, the Somerset Pressure Ulcer Collaborative, the Somerset Strategic Infection Prevention and Control and Antimicrobial Assurance Committee Meeting, Adult and Children's Local Safeguarding boards and associated subgroups and many more examples of shared work programmes

- Somerset has a strong history of collaborative working on medicines optimisation - ensuring the safe and cost effective use of medicines across the healthcare system. Somerset operates a joint formulary and prescribing guidance and uses the eclipse live safety system to facilitate the reduction in medicines related admissions. Somerset is a high achieving system when benchmarked against many national prescribing indicators

- Somerset has reviewed the evidence base and updated its procedures of limited clinical effectiveness policies over the last three years

2.82 Furthermore the CCG receives independent external assurance from regulatory bodies with which service providers are registered, namely the Care Quality Commission and NHS Improvement.

Corporate Services

2.83 The range of services contracted by the CCG to support our corporate functions include:

- the South, Central and West Commissioning Support Unit (CSU) – IT support
- NHS Property Services – building lease and maintenance
- Somerset Partnership NHS Foundation Trust – for payroll service

2.84 The CCG operates similar contract review arrangements for third party corporate service providers to those for healthcare providers through contract review arrangements.

2.85 Other routes for obtaining assurance from third party corporate service providers are through a requirement for those service providers to engage and participate in the CCG internal governance arrangements, to control and obtain assurances in relation to our work programmes, such as through:

- IM&T Strategy Group
- Somerset Digital reference Group
- Information Governance and Health Care Records and Caldicott Committee

2.86 The South, Central and West Commissioning Support Unit commission a Service Auditor Report from its internal Auditors, Deloitte, which monitors and reports on the control objectives of all its services. For the CCG this specifically covers IT Support and Procurement, the result of which is reported to the CCG Audit Committee, with any actions taken up with the CSU.

2.87 The Clinical Commissioning Group also uses its Internal Audit and Counter Fraud Services to provide necessary assurances as part of their work plans. Outcomes of this work are reported to the CCGs Audit Committee where assurances are obtained and any actions/improvements agreed and implementation is monitored. In 2017/18 the CCGs Internal Auditors undertook a review of payroll services and recommendations and actions were reported to the CCGs Audit Committee including actions. The audit report received a substantial assurance rating.

2.88 During 2017/18 Somerset CCG has continued to work with our statutory and strategic partners in Somerset to develop the Somerset Sustainability and Transformation Plan (STP) and towards future contractual

arrangement for a Somerset community wide outcomes based contract with a single Accountable Provider Organisation (APO). The Somerset approach to managing the system as a single health and care system, supported by a long term strategy is being developed, with the more immediate development of a three year financial recovery plan, to ensure alignment and delivery of the triple aims for the system as a whole. As part of the developing and continued working towards a single system on the financial, activity and workforce the individual operational plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery, in 2017/18 and forwards from here. These arrangements will require a revised approach to obtaining third party assurances and the CCG will need to be assured of the capability of the APO to both obtain and provide assurance about commissioned and contracted services. This presents a new challenge for the CCG in taking corporate risk management and assurance forward into new arrangements for the commissioning of health services in the future. During 2017/18 the extent of this activity has been limited to establishing a work programme to deliver the aims and objectives of the STP. In 2018/19 work will need to be progressed to work towards a different assurance framework across and between participating agencies in the STP.

2.89 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.

2.90 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

2.91 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 against identified risks.

Pension Obligations

2.92 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.

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

2.93 The CCG has an approved Risk Management Strategy and Policy which 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

2.94 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.

2.95 The CCG recognises the strategic benefits to be achieved through risk management which include:

- 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

2.96 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

2.97 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

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

2.99 The overall CCG committee level responsibility for risk management rests with the Governance Committee. Other CCG groups with responsibility for risk management during 2017/18 have been:

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

2.100 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.

2.101 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

2.102 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

2.103 At 31 March 2018 there were 18 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). During 2017/18 there has been an increase in the level of risk that the CCG has been exposed to and this has been reflected through the risk register. The financial constraints being faced by the NHS together with the pressures of managing increasingly complex care for an ageing population has increased the risk profile of the CCG. The risk management system has been effective in capturing these risks and enabling the Governing Body to have a good insight into the strategic risks being faced and the mitigating actions being undertaken.

2.104 The red risks identified as at 31 March 2017 were:

- failure of T&S FT to meet constitutional targets will impact adversely on patient experience
- quality and safety concerns over the out of hours provision
- pressure on the prescribing budget
- financial situation at Yeovil District Hospital
- risk of failure to achieve ambulance category 1calls target
- risk of overspend or reduction in services to meet 2017-2017 budget provision
- adult mental health services not always able to meet immediate needs of all people
- failure to meet trajectories for seeing increased number of children and young people in CAMHS service
- YDH and TST contracts for 2017/2018 are PbR funded which increases costs as activity increases
- financial pressure if QIPP schemes unable to deliver targets
- delays for ambulances due to high levels of demand (ie. Call Stacking) (Ambulance)
- increased demand on urgent care leading to delays in care, compromised patient experience and increased costs
- CCG Leadership capacity and capability
- cost of delivering new wheelchair services exceeds the current contract value
- Dementia Diagnosis Rate presents risk of people not receiving early diagnosis to support future care planning
- Dementia Annual Care Plan Review for people diagnosed with dementia
- future sustainability of services at Weston Area Health Trust
- risk to finance if the budget allocated to PbR Excluded Drugs is insufficient to manage patients being treated in acute care setting

2.105 The remaining 10 risks on the Corporate Risk Register were all scored as amber (rating of 12).

2.106 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.

2.107 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

2.108 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.

2.109 At the beginning of 2017/18, the Audit Committee reviewed its Terms of Reference and as part of this also undertook an assessment against 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 2017/18.

2.110 The Audit Committee receives regular reports from Internal and External Audit and Counter Fraud.

2.111 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.

2.112 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 the NHS Counter Fraud Authority. The CCG engages an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work across the whole organisation. During 2017/18 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority strategy to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all four key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

2.113 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 the Chief Finance

Officer and Director of Performance in conducting that work. In 2017/18 the Local Counter Fraud Service supported the submission of the CCGs Self review Tool (SRT) in accordance with the Standards for Commissioners – Fraud, Bribery and Corruption.

2.114 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.

2.115 In 2017/18 the CCGs LCFS delivered a training session to CCG staff, and the CCG also shared LCFS briefings with all staff through its 60 seconds bulletin, which covers key areas of learning from within the sector.

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

2.117 The CCG continues to set a challenging QIPP programme, which sees projected QIPP savings in excess of £31m being delivered in 2017/18. These QIPP schemes are vigorously monitored 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.

2.118 The CCG is looking at all opportunities for cost savings through demand management schemes and are agreeing these with system partners.

2.119 To support this, the CCG has set up a finance group chaired by the Chair of the Audit Committee of the CCG which is looking at the financial position and QIPP opportunities across the range of services commissioned. This group meets monthly to review the position and has an active work programme which is being actioned through the CCGs Leadership team.

2.120 As part of the developing and continued working towards a single system on the financial, activity and workforce the individual operational plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery, in 2017/18 and forwards from here. The

Somerset approach to managing the system as a single health and care system, supported by a long term strategy is being developed, with the more immediate development of a three year financial recovery plan, to ensure alignment and delivery of the triple aims for the system as a whole. This forward strategy will build on and refresh the already STP approved estates workbook, capital plans, and digital plans. The recovery plan will focus on managing demand and reducing cost across the system. This will include a focus on clinical variation (using Rightcare, Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks) is looking at elective and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care. We are also planning a system-wide approach to the efficient and cost effective use of bed capacity across all STP Partners.

The Better Care Fund

2.121 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 2017/18 through a signed agreement under Section 75 of the National Health Service Act 2006. Somerset County Council received additional funding in 2017/18 through the improved Better Care Fund (iBCF), which has been pooled as part of the Section 75 agreement. The iBCF funding can be spent on three purposes:

- meeting adult social care needs
- reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- ensuring that the local social care provider market is supported

2.122 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.

2.123 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.

2.124 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
- NHS contribution to adult social care is maintained in line with inflation
- agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care

- managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings)

2.125 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 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

2.126 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
- non-elective admissions (general and Acute) – reduce emergency admissions to hospital

2.127 The Health and Wellbeing Board, the CCG Governing Body, 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

Control Issues

2.128 In January 2018, a month 9 Governance Statement Report was submitted to NHS England. This return highlighted one area of control where significant performance issues have been experienced during 2017/18. These areas, along with the mitigating actions, are shown in the table below.

Control Issue	Mitigating Actions in Place
Organisational performance	Performance - The CCG has put in controls for managing provider performance, including a monthly Access and Performance Group Meetings (APG) with Taunton and Somerset NHS Foundation Trust (Yeovil District Hospitals Foundation Trust would be restated should access performance decline), which includes regulator attendance. The Clinical Commissioning Group has performance recovery action plans from both providers, which are monitored through the APG for each area of underperformance. Somerset Clinical Commissioning Group applies contract performance notices where appropriate with all Providers where the CCG is the lead commissioner (Taunton & Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust, Somerset Partnership NHS Foundation Trust, Care UK and Vocare) and enacts all appropriate contract levers in terms of financial sanctions (whereby the objective is not assessed as part of the Sustainability and Transformation Fund). Remedial Action Plans are developed by the Provider in conjunction with the commissioner and progress is closely tracked. The following RAPs are in place: • A&E 4 Hours standard, aligned to the 5 nationally mandated improvement actions - T&S • RTT Incompletes (all specialities) - T&S (including outcome of VIST review which has now concluded) • 62 day Cancer - T&S, YDH • Diagnostics - T&S • NHS 111 and Out of Hours – Vocare • IAPT access standards and moving to recovery – Somerset Partnership

	The RAPS remain under continual review with progress monitored; the CCG is in attendance at the number of internal Trust meetings (including the weekly RTT PTL and monthly diagnostic meetings) and where there is any divergence from plans immediate actions are put in place to address this shortfall or new actions are agreed to address any emerging issues. The Clinical Commissioning Group has also commissioned additional activity through the independent sector during 2017/18 with patients being offered this choice through the Referral Management Centre. The Clinical Commissioning Group continues to work with the system to implement schemes for demand management, which include: • referral benchmarking for individual GP Practices and Federations • extending Consultant and Urgent Connect (Advice and Guidance) • patient initiated follow up outpatient scheme • extending the coverage and continuing with the 2 existing GP 999 Cars • review of other referral demand in order to identify areas of unwarranted variation with improvement schemes agreed as required. The Clinical Commissioning Group is strengthening the monitoring and oversight of the national Clinical Commissioning Group assurance framework and linking this with reporting to the Governing Body within the Clinical Commissioning Group Governance Framework, with improvement plans developed for any areas of underperformance. The CCG continues to work with the system to identify areas for demand management opportunity, which include: • continued review of referral benchmarking for individual GP practices and federations • enhancing the patient initiated follow up outpatient scheme • enhancing Advice and Guidance schemes such as Consultant Connect

Counter Fraud Arrangements

2.129 The 2017/18 Annual Counter Fraud Work Plan was developed to support the CCG in implementing appropriate measures to counter fraud, bribery and corruption. Having appropriate measures in place helps to protect NHS resources against fraud and ensures they are used for their intended purpose, the delivery of patient care.

2.130 The Counter Fraud work plan for 2017/18 was risk-based and has been aligned to the Standards issued by NHS Protect in January 2017. The work plan was produced taking into account:

- discussions with the Chief Finance Officer and Director of Performance and members of the Audit Committee
- local proactive work, risk measurement exercises and evaluation of previous work conducted at the CCG by the LCFS and CCG staff
- risks identified from referrals received and investigations conducted at the CCG by the LCFS
- risks identified at other clients either locally or nationally by NHS Protect
- any national programme of proactive work by NHS Protect

2.131 The Counter Fraud service is provided by TIAA, which includes a local accredited Counter Fraud Specialist (LCFS) who ensures that the annual work plan is delivered. Regular progress reports are provided at each Audit Committee meeting detailing the progress against each element of the work plan. In addition, an annual report is produced showing the assessment against each of the commissioner standards, including any actions which need to be taken in order to ensure the standard is achieved.

2.132 The overall executive lead for counter fraud is Alison Henly, Chief Finance Officer and Director of Performance, who is responsible for proactively tackling fraud, bribery and corruption.

Head of Internal Audit Opinion

2.133 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:

Opinion

The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework 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 has continued to face financial challenges and is reporting a forecast deficit of £0.5m (PY: £9.9m).
- The CCG has displayed strong key financial system controls in relation to payroll and expenses. They have also addressed recommendations raised through the Information Governance Toolkit review in a timely manner to ensure they were implemented before the 2018/19 submission.
- One report is part limited assurance relating to Children Care Plans. However this area of risk was highlighted by management and the assurance level is consistent with their expectations. This demonstrates the CCG's awareness of their risk areas, and their proactivity in engaging with Internal audit to ensure they are addressed. This report is currently being agreed and finalised with management.

2.134 During the year, Internal Audit issued the following audit **r**eports:

Area of Audit	**Director**	**Level of Assurance Given**
Key Financial Systems – Payroll, Expenses and GP enhanced Services	Alison Henly Chief Finance Officer and Director of Performance	**Design**: substantial **Effectiveness**: moderate **Recommendations**: 2 medium significance, 2 low significance Summary of report: As part of our rotational review of the key financial systems, we have analysed the controls surrounding payroll and expenses. Additionally and at the request of management, we have included a review of GP enhanced services. The review noted the following areas of good practice:

		• Physical security and system access to ESR were well maintained during the course of the audit. • There is a robust system in place for reporting payroll data and ensuring the accuracy and validity of data prior to the payroll being run. • Due to the size of the organisation and payroll being located within the same premises there are clear examples of collaborative working, correcting and discussing inaccuracies to prevent any errors in the pay run and to work more efficiently. • The CCG has an expenses policy that is made available to all employees through the intranet. The principles of the expense policy were generally well understood as evidenced by our expenses sample testing. • There are clear processes and procedures in relation to GP enhanced services, including a number of verification checks to ensure activity levels are in accordance with budgets and payments are calculated correctly. **Opportunities for enhancement** Recommendations have been raised against each of the areas of the assessment and summarised below: • The CCG should implement an electronic expenses system and ensure this is being used by staff to capture their travel and expenses. For example, the system used by Somerset Partnership (Allocate) is cost effective and the current payroll team can assist the CCG in implementation across the organisation. • The CCG should ensure that starters, leavers and change forms are sent to payroll promptly to minimise the likelihood of overpayments / delays in paying staff. The CCG should ensure that the policies and procedures are subject to regular review, this should also include updates following key changes to taxable benefits. The CCG should implement a spot checking exercise on an annual basis to confirm the data held within the quality returns is accurate. The intention to undertake this spot check should be widely communicated to all practices to act as

		a fraud deterrent.
Conflicts of Interest	Paul Goodwin Director of Commissioning Reform	**Design:** moderate **Effectiveness:** moderate **Recommendations:** 9 medium significance, 2 low significance **Summary of report:** The review involved undertaking an internal audit of the CCG's conflicts of interest management processes as required by the revised conflicts of interest guidance (June 2017) issued by NHS England. The purpose of the review was to confirm and obtain assurance that the safeguards set out in the revised statutory guidance for managing conflicts of interest have been embedded within the CCG. The following aspects of the CCG's management of conflicts of interest were considered to be good practice: • The CCG has documented procedures in place to ensure that conflicts of interest are identified, declared and escalated to the appropriate register in a timely manner, facilitated by the online register system which reduces the level of admin required and effectively streamlines the process. • The online register system facilitates automatic reminders to be sent out to alert individuals when they need to update their declarations. The system also allows for reports to be run to identify who has failed to update their declarations within the permitted timeframes. • The CCG has implemented procedures to ensure that any potential contractors are required to declare any potential conflicts of interest during the tender process to facilitate consideration of these during the procurement process. **Opportunities for enhancement** Recommendations have been raised against each of the areas of the assessment and summarised below: • The Standards of Business Conduct and Conflicts of Interest policy is not fully compliant with the criteria set out in the statutory guidance published by NHS England. • The CCG has no process for

		monitoring compliance with reading the conflicts of interest training slides as there is no comprehension test or submission of completion associated with the training. • Declarations of interest are not consistently completed during the recruitment process, with some declarations being completed and signed after the member of staff is recorded as having started in their role • CCG documentation does not clearly differentiate between Non-Executive Directors and Lay members, with both commonly being referred to as Non-Executive Directors with a lack of indication as to which NEDs are Lay Members • The conflicts of interest checklist used at committee meetings is not appended to the CCG conflicts of interest policy which is a requirement of statutory guidance • Not all individuals who are required to make declarations of interest, including nil returns, have a record of declaration on the online system. Additionally we identified instances where declarations were not dated or were older than the six month requirement • The details recorded within the registers of interest, gifts and hospitality and procurement decisions are not always sufficient to comply with the requirements of statutory guidance or to provide the reader with sufficient detail on the nature of the conflict in question and how it will be managed • Individual registers of interest are published for certain CCG committees which are not always consistent with the published all staff register. Additionally, the amount of information and level of detail within the individual registers is lower than the all staff register • A review of minutes from various CCG committee meetings identified that when a conflict of interest is identified during a meeting the minutes do not always record sufficient details as set out in the statutory guidance • There is a lack of clear guidance on what procedures should be undertaken during the contract monitoring process to ensure conflicts of interest are

		identified and managed appropriately throughout the contract. The policy should also include procedures to follow when there is a breach in policy which effects a contract that has already been entered into. There is also a lack of detail within minutes of contract monitoring groups relating to conflicts of interest discussions which occurred
Risk Maturity Assessment	Sandra Corry – Director of Quality and Safety	The purpose of the risk maturity assessment is to help ensure an effective risk management culture becomes embedded across the Clinical Commissioning Group, by highlighting areas where processes could be improved. As a primarily advisory piece of work, this assessment will not generate an assurance opinion. The following aspect of the CCG's risk management processes were considered to be good practice: • The CCG has clear themed strategic objectives. • Roles and responsibilities for risk management have been defined centrally and across divisions and departments; the CCG has a dedicated Risk Manager and Risk leads, and a Risk Management Strategy which provides the fundamentals and a framework for a sound system of risk management within a high risk area of the CCG. • All staff joining the CCG are provided with an overview of risk management and their responsibilities within the risk management system during induction. Senior staff with a greater level of responsibility for risk management are provided with more in depth training sessions. Additionally the CCG Risk Manager is available where necessary to provide further guidance to any individuals who require it. • The corporate risk register is reviewed by the Governance Committee and then reported to the Governing Body on a quarterly basis. • All risks recorded in the risk register record the associated controls in place to mitigate the risk, together with any actions planned to introduce further control. Risk scores are revaluated on

		a regular basis. **Opportunities for enhancement** Recommendations have been raised against each of the areas of the assessment and summarised below: • The CCG should include a formal risk appetite statement in its Risk Management Strategy, to better define the tolerable level of risk with which the organisation is willing to operate. This should be formally agreed by the Governing Body. • Performance information should be linked to the Corporate Governance Oversight using the NHS England's CCG Improvement and Assessment Framework, which should be clearly linked and presented in such a way to equip Members of the Governing Body with an easily digestible and concise overview of strategic risks associated with the CCG. An example is included at Appendix III. • Members of the Clinical Operations Group and staff moving to more senior roles with additional responsibilities in risk management should attend the induction training for risk management • The CCG should implement target risk scores for each risk, ensuring these are realistic and meaningful. This will then allow the CCG to ensure they identify any material deviation from the target risk score from the defined and agreed time periods. This should form a key part of the discussion surrounding risk management. • KPIs should be used to measure the effectiveness of risk management activity at the Trust. This can include the proportion of risks operating at the target level, the overall effectiveness of risk management (current risk versus target risk etc).
Complex Children Care Plans	Sandra Corry – Director of Quality and Safety	**Design:** moderate **Effectiveness:** limited **Recommendations:** 1 high significance, 3 medium significance, 3 low significance **Summary of report:** The purpose of our review was to ensure the CCG has a robust process in place for working with other organisations to

		develop care plans for complex children and to monitor their effectiveness. We were requested to review this area by Somerset CCG as it was seen as an area of significant risk. **The following areas of good practice were identified:** • A Multi-Agency Protocol has been established for children with complex needs • An operational plan has been established for the CCG, which outlines the procedures to follow for children with complex needs that do not fit the criteria for multi agency funding • Minutes of the Multi Agency Panel reviewed for the period August 2017 to December 2017 confirmed that the meetings were always attended by at least by 1 delegate from the CCG, which represents approximately 10% of attendees and 15% of decision-makers. • Testing confirmed that once children are identified with complex needs, they are referred appropriately within a timely manner **Opportunities for enhancement** Recommendations have been raised against each of the areas of the assessment and summarised below: • The Governance of minutes to the Multi Agency Panel is insufficient; there is no process to review and approve minutes, and decision sheets are consistently incomplete and not signed by all Panel Agency representatives. Additionally care plan package costings are not itemised and presented to the Panel to support the decision-making process and percentage funding split agreement, and there is no summarised record or individual tracking of actions taken which is available to all Agencies within the Panel (Finding 1 – High) • Communication relating to feedback to the SCCG Panel from the Multi-Agency Panel is inadequate and it is unclear whether placements funded by SCCG have been reviewed as agreed and alternative funding arrangements made

		(Finding 2 – Medium) • The Multi-Agency Complex Children Panels Terms of Reference does not record the quorum for decision making and allows for decisions to be taken on behalf of the CCG when they are not present (Finding 3 – Medium)

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

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

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

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

2.138 I have been advised on the implications of the result of this 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.

Conclusion

2.139 The role and conclusions of each 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: Nick Robinson

Nick Robinson

Accountable Officer

Somerset Clinical Commissioning Group

Date: 24 May 2018

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 2018 are listed below grouped within their Commissioning Locality.

Bridgwater Bay Health

- Cannington Health Centre
- Cranleigh Gardens Medical Centre
- Polden Medical Practice
- East Quay Medical Centre
- North Petherton Surgery
- Quantock Medical Centre
- Redgate Medical Centre
- Somerset Bridge Medical Centre
- Taunton Road Medical Centre
- Victoria Park Medical Centre

Central Mendip

- Oakhill Surgery
- Grove House Surgery
- Park Medical Practice

Chard, Crewkerne and Ilminster

- West One Surgery
- Summervale Surgery
- Essex House Medical Centre
- Meadows Surgery
- Springmead Surgery
- Tawstock Medical Centre
- Church View Medical Centre
- Langport Surgery

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 Medical Practice
- Cheddar Medical Centre
- Highbridge Medical Centre

Taunton and Area

- North Curry Health Centre
- Creech Medical Centre
- Warwick House Medical Centre

- College Way Surgery
- Taunton Vale Health Centre
- 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
- Buttercross Health Centre
- Ilchester Surgery
- Ryalls Park Medical Centre
- Oaklands Surgery
- Penn Hill Surgery
- Hendford Lodge Medical Centre
- Preston Grove Medical Centre
- Abbey Manor Medical Practice
- West Coker Surgery
- Hamdon Medical Centre
- Church Street Surgery
- Crewkerne Health Centre

West Mendip
- Wells City Practice
- Wells Health Centre
- Glastonbury Surgery
- Glastonbury Health Centre
- The Vine Surgery (Vriend)
- The Vine Surgery (Da Cunha)

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

Annex 2 (Governance Statement)

Somerset CCG Governing Body Meetings 2017/18– Attendance Record										✓ = Present X = Apologies Given	
(V) = voting Member (NV) = non-voting Member	27.04.17	25.05.17	22.06.17	20.07.17	14.09.17	19.10.17	16.11.17	14.12.17	25.01.18	22.02.18	22.03.18
Dr Ed Ford (V) Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	X	✓	✓	✓	✓	✓	X	X	✓
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	X	✓	✓	✓	✓	✓	✓	X	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	X	✓	X	✓	✓	✓	X	✓
Dr Will Harris (V) Chair of the Clinical Operations Group to September 2017	✓	✓	✓	X	✓						
David Heath (V) Non-Executive Director, Patient and Public Engagement		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer and Director of Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Alex Murray (V) Governing Body GP, and COG Chair with effect from Oct 2017		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Nick Robinson (V) Chief Officer with effect from August 2017					✓	✓	X	✓	✓	✓	✓
David Slack (V) Managing Director/Accountable Officer to August 2017	✓	✓	✓	✓							
Sandra Corry (NV) Director of Quality and Patient Safety	✓	✓	✓	✓	X	X	X	X	✓	✓	✓
Deborah Rigby (NV) Acting Director of Quality and Patient Safety (Sept-Dec 2017)					✓	✓	✓	✓			
Paul Goodwin (NV) Director of Commissioning Reform	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	
Dr Rosie Benneyworth (NV) Director of Strategic Clinical Services Transformation							✓	✓	✓	✓	X
Peter Rowe (NV) PPG Lay Observer (to July 2017)	X	X	✓	✓							
Sandra Wilson (NV) PPG Lay Observer (from September 2017)					✓	✓	✓	X	X	X	✓

Somerset CCG Governing Body Meetings 2017/18– Attendance Record										✓ = Present X = Apologies Given	
(V) = voting Member (NV) = non-voting Member	27.04.17	25.05.17	22.06.17	20.07.17	14.09.17	19.10.17	16.11.17	14.12.17	25.01.18	22.02.18	22.03.18
Dr Harry Yoxall (NV) Local Medical Committee (Observer)	✓	X	✓	X	✓	✓	X	X	✓	✓	
Judith Goodchild (NV) Healthwatch Observer	X	X	X	X	✓	X			✓	X	✓
Christine Graves (NV), Chair of the Board of Directors of Evolving Communities, temporarily representing Healthwatch							✓	X			

Somerset CCG COG Meetings
2017/18 – Attendance Record

✓ = Present
X = Apologies Given

(V) = voting Member (NV) = non-voting Member	**5 Apr 17**	**10 May 17**	**14 Jun 17**	**12 Jul 17**	**6 Sep 17**	**4 Oct 17**	**1 Nov 17**	**6 Dec 17**	**7 Feb 18**	**7 Mar 18**
Dr Rob Allen (V), East Mendip Commissioning Locality Delegate	✓	✓	✓	✓	✓	X	X	Vacancy – Left the CCG at the end of November 2017		
Dr Helen Kingston (V), East Mendip Commissioning Locality Delegate	Joined the COG in March 2018 – Replaced Rob Allen									✓
Dr Rosie Benneyworth (V), Director of Strategic Clinical Services Transformation	Not in post – joined the CCG in November 2017						✓	✓	X	X
Stephen Chandler (V), Director of Social Services, Somerset County Council	X	X	X	X	X	✓	X	X	X	X
Dr Will Chandler (V), Taunton Deane Commissioning Locality Delegate	✓	✓	✓	✓	X	✓	✓	X	✓	X
Sandra Corry (V), Director of Quality, Safety and Engagement	X	X	✓	✓	✓	(DR)	(SG)	(DR)	(DR)	(SG)
Dr Steve Edgar (V), South Somerset Commissioning Locality Delegate (job share position with Dr Ian Wyer)	Joined the COG in December 2017– Replaced Daniel Vincent							✓	✓	✓
Dr Ed Ford (V), West Somerset Commissioning Locality Delegate	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Paul Goodwin (V), Director of Commissioning Reform and Governance	✓	✓	X	X	X	✓	✓	X	✓	
Dr Will Harris (V), COG Chair*1 and West Mendip Commissioning Locality Delegate	✓	✓	✓	✓	✓	Left the COG at the end of September 2017				
Alison Henly (V), Chief Finance Officer and Director of Performance	✓	✓	✓	✓	✓	✓	X	X	✓	✓
Peter Hillman (NV), Lay Members' Representative	✓	X	✓	✓	X	✓	✓	✓	✓	✓
Marianne King (NV), Associate Director of Human Resources and Organisational Development	Joined the COG in November 2017						X	X	X	X
Dr Joey McHugh (V), COG Vice Chair and North	✓	✓	✓	✓	✓	X	✓	✓	✓	✓

(V) = voting Member (NV) = non-voting Member	5 Apr 17	10 May 17	14 Jun 17	12 Jul 17	6 Sep 17	4 Oct 17	1 Nov 17	6 Dec 17	7 Feb 18	7 Mar 18
Sedgemoor Commissioning Locality Delegate										
Trudi Mann (V), Practice Managers' Delegate	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Dr Alex Murray (V), COG Chair*1 (wef: October 2017) and Bridgwater Bay Commissioning Locality Delegate	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Dr Amelia Randle (V), Central and West Mendip Commissioning Localities' Delegate	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Nick Robinson (V), Chief Officer	Joined the CCG in August 2017				✓	X	✓	X	✓	X
David Slack (V), Managing Director/ Accountable Officer	✓	✓	✓	✓	Left the CCG in August 2017					
Dr Kate Staveley (V) Chard, Crewkerne and Ilminster Commissioning Locality Delegate	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Dr Karen Sylvester (NV) GP & LMC Representative	✓	✓	✓	X	✓	X	✓	✓	X	✓
Tracey Tilsley (NV) Head of Business and Strategy	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Daniel Vincent (V) Interim South Somerset Locality Delegate	✓	✓	✓	X	X	✓	✓	Left the CCG at the end of November 2017		
Dr Ian Wyer (V), South Somerset Commissioning Locality Delegate (job share position with Dr Steve Edgar)	Joined the COG in December 2017 – Replaced Daniel Vincent							✓	✓	✓

Initials in brackets indicate deputising arrangements as follows:

DR(Debbie Rigby) / Shaun Green (SG) attended on behalf of Sandra Corry when Sandra was unavailable.

*1 Dr Will Harris was the COG Chair until the end of September 2017 after which Dr Alex Murray became the COG Chair as well retaining her role as Bridgwater Bay Commissioning Locality Delegate

Somerset CCG Audit Committee Meetings 2017/18 – Attendance Record

✓ = Present
X = Apologies Given

Name	**Member (M)/ In Attendance (A)**	**17 May 2017**	**19 July 2017**	**20 Sept 2017**	**13 Dec 2017**	**28 Feb 2018**
Lou Evans Audit Committee Chair and Non-Executive Director	M	✓	✓	✓	✓	✓
David Bell Non-Executive Director	M	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark Non-Executive Director Registered Nurse	M	✓	✓	✓	X	✓
Dr Geoff Sharp GP Member	M	✓	X	✓	✓	X
Alison Henly Chief Finance Officer and Director of Performance	A	✓	✓	✓	✓	X

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 2017/18 – Attendance Record

✓ = Present
X = Apologies Given

(M) Committee member (A) In attendance	3 May 2017	26 Jul 2017	25 Oct 2017	31 Jan 2018
Dr Ed Ford (M) Chair and GP Governing Body Member	✓	✓	✓	✓
Sandra Corry Director of Quality, Safety and Engagement	✓	✓	X (DR)	X (DR)
Lou Evans (M) Vice Chair and Non-Executive Director, Governance and Audit	✓	X	✓	X
Dr Jayne Chidgey-Clark (M) Non-Executive Director, Registered Nurse	✓	✓	X	X
Dr Will Harris (M) Chair of the Clinical Operations Group and GP Governing Body Member	X	X		
Alison Henly (M) Chief Finance Officer and Director of Performance	✓	X (HF)	X (AR)	X (AR)
Dr Basil Fozard (M) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓	✓	✓
Paul Goodwin (M) Director of Commissioning and Governance	✓	✓	✓	X
David Heath (M) Non-Executive Director, Patient and Public Engagement	✓	✓	X	X
Dr Alex Murray (M) Chair, Clinical Operations Group, Governing Body GP member			X	X
Nick Robinson (M) Chief Officer			X	X
David Slack (M) Managing Director	✓	✓		
Karen Taylor (A) Head of Patient Safety and Governance	✓	✓	✓	✓
Peter Osborne (A) Corporate Governance Manager	✓	✓	✓	✓

Where initials are indicated in the table above, deputies attended on behalf of Sandra Corry and Alison Henly as follows:

- Helena Fuller, Deputy Director of Acute Programme Transformation and Commissioning
- Deborah Rigby, Deputy Director of Quality, Safety and Engagement
- Alison Rowswell, Head of Urgent Care and Programme Management

Somerset CCG Remuneration Committee Meetings 2017/18
Attendance Record

✓ = Present X = Apologies Given V = voting NV = non-voting	25.05.17	14.07.17	14.09.17	14.12.17	02.03.18 (Telecon)
Lou Evans (V) Remuneration Committee Chair, and CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	X	✓	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	✓	✓	✓	✓	✓
Nick Robinson (NV) Chief Officer with effect from August 2017			✓	✓	X
David Slack (NV) Managing Director/Accountable Officer to August 2017	✓	✓			
Note: No additional persons attended the Committee in order to provide legal advice on compliance with any relevant legislation.					

Somerset Primary Care Joint Committee Meetings ✓ = Present
2017/18 – Attendance Record X = Apologies Given

* Attendance as requested by CCG Chair

(M) Committee member (A) In attendance	Job Title	Committee Role (e.g. Executive, Lay, GP,)	8 Jun 17	31 Aug 17	30 Nov 17	8 Mar 18
David Bell (M)	Non-Executive Director Lay Member, Chair of the Somerset Primary Care Joint Committee – Somerset CCG	Chair Non-Exec	✓	✓	✓	✓
Lou Evans (M)	Vice-Chair, Non-Executive Director Lay Member, Governance and Audit– Somerset CCG	Vice Chair Non-Exec	X	X	X	✓
Paul Goodwin (M)	Deputy Chief Officer and Director of Commissioning and Governance – Somerset CCG	CCG	X	✓	✓	
Alison Henly (M)	Chief Finance Officer and Director of Performance – Somerset CCG	CCG	✓	✓	X	✓
Dr Rosie Benneyworth (M)	Director of Strategic Clinical Services Transformation	CCG	✓	X	X	X
* Dr Jayne Chidgey-Clark (M)	Non-Executive Director, Registered Nurse – Somerset CCG	Non-Exec	X	X	X	X
Sandra Corry (M)	Director of Quality and Safety– Somerset CCG	CCG	X	X	X	X
Laila Pennington (M)	Head of Primary Care, NHS England	NHS E	✓	✓	✓	X
Amanda Fisk (M)	Director of Assurance & Delivery, NHS England	NHS E				✓
Louise Woolway (M)	Public Health Consultant, Somerset County Council – Somerset CCG	SCC	✓	✓	✓	✓
Dr Basil Fozard (M)	Non-Executive Director, Secondary Care Specialist Doctor, Somerset CCG	Non-Exec	✓	✓	✓	✓
David Health (M)	Non- Executive Director Lay Member, PPE - Somerset CCG	CCG	✓	✓	✓	✓
Dr Will Harris (M)	Chair of COG – Somerset CCG	GP	✓	✓	✓	✓
John Burrows (M)	Assistant Head of Finance (Primary Care), NHS England	NHS E	✓	✓	✓	X
Kevin Davis (M)	Head of Finance, NHS England	NHS E	X	X	X	✓
Dr Chris Campbell (M)	External GP Member	External GP	✓	✓	X	✓
Martin Davidson (M)	PPG Chairs Representative, Somerset CCG	PPG Chair Rep	✓	✓	✓	✓
Dr Nick Bray (M)	Chairman, Somerset Local Medical Committee	LMC	X	✓	✓	X
Dr Kate Staveley (M)	COG GP Representative	GP	✓	✓	✓	✓
Tariq White (M)	Assistant Director of Transformation and Outcomes, NHS England South (South West)	NHS E	X	X	X	X
Anne Woodford / Jacqueline Briggs (M)	Healthwatch Representative	Healthwatch	X	X	X	X
Tanya Whittle (A)	Associate Director: Community Services and Primary Care, Somerset CCG	CCG	✓	✓	X	✓
Michael Bainbridge (A)	Head of Primary Care	CCG	✓	✓	✓	✓
Karen Taylor (A)	Acting Deputy Director/ Head of Patient Safety & Risk Management	CCG	✓	✓	✓	✓
Debbie Hillier (Attended on behalf of Alison Henly) (A)	Deputy CFO and Deputy Director of Performance	CCG			✓	

Remuneration and Staff Report

Remuneration Report

2.140 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.

2.141 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.

2.142 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.

2.143 The table below details the remuneration levels for all senior managers in the CCG.

Senior manager remuneration (including salary and pension entitlements)

		Total 2017/18						Total 2016/17					
		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
Nick Robinson	Chief Officer	95-100	0	0	0	0	95-100	0	0	0	0	0	0
David Slack	Managing Director/ Accountable Officer	45-50	0	0	0	0-2.5	45-50	125-130	0	0	0	55-57.5	180-185
Alison Henly	Chief Finance Officer and Director of Performance	100-105	60	0	0	17.5-20	125-130	100-105	56	0	0	30-32.5	140-145
Rosie Benneyworth	Director of Strategic Clinical Services Transformation	50-55	0	0	0	57.5-60	105-110	0	0	0	0	0	0
Paul Goodwin	Director of Commissioning and Governance	95-100	39	0	0	12.5-15	115-120	105-110	40	0	0	10-12.5	125-130
Sandra Corry	Director of Quality, Safety and Engagement	90-95	0	0	0	50-52.5	140-145	30-35	0	0	0	80-82.5	110-115

Edward Ford	Chair	75-80	0	0	0	27.5-30	105-110	60-65	0	0	0	15-17.5	75-80
Will Harris	COG Chair	25-30	0	0	0	90-92.5	120-125	15-20	0	0	0	87.5-90	105-110
Alex Murray	COG Chair	60-65	0	0	0	122.5-125	185-190	0	0	0	0	0	0
David Bell	Non Exec Director	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Lou Evans	Lay Member (Vice-Chair)	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
David Heath	Non Exec Director	5-10	0	0	0	0	5-10	0	0	0	0	0	0
Basil Fozard	Secondary Care Doctor	5-10	0	0	0	0	5-10	0-5	0	0	0	0	0-5
Jayne Chidgey-Clark	Registered Nurse	15-20	0	0	0	0	15-20	10-15	0	0	0	0	10-15
Deborah Rigby	Acting Director of Quality, Safety and Engagement	40-45	0	0	0	42.5-45	85-90	10-15	0	0	0	27.5-30	35-40

Officer Holder Changes:

Nick Robinson was appointed to the post of Chief Officer from August 2017
David Slack left the post of Managing Director in August 2017, however was paid in lieu of notice until December 2017. Mr Slack's pay post August has been excluded from the Remuneration report as he was no longer an office holder.
Dr Rosie Benneyworth was appointed to the post of Director of Strategic Clinical Services Transformation in October 2017
Paul Goodwin left the post of Director of Commissioning and Governance in February 2018 when he was seconded to the BANES STP. Mr Goodwin continued to be paid by Somerset CCG until the 31 March 2018, although his pay post February has been excluded from the Remuneration report as he was no longer an office holder.
Deborah Rigby was seconded to the post of Acting Director of Quality, Safety and Engagement in September 2017 until March 2018
Dr Will Harris left the post of COG Chair in September 2017
Dr Alex Murray was appointed to the post of Clinical Lead: Mental Health and Dementia in May 2017 and then to the post of COG Chair in October 2017
David Heath was appointed to the post of Non-Executive Director, Patient and Public Engagement in June 2017

In addition the following individuals were seconded to the Sustainability Transformation Plan and these roles are not reflected in the above table:
Dr Rosie Benneyworth held the post of GP Provider Role from April 2017 and left the post in October 2017.
Lou Evans has completed some work for the Sustainability Transformation Plan and any remuneration associated with this is excluded from the table above

Other Notes:
A Somerset Turnaround team was contracted on behalf of Somerset Clinical Commissioning Group, Taunton and Somerset NHS Foundation Trust, Yeovil District Hospitals NHS Foundation Trust and Somerset Partnership NHS Foundation Trust. This was supported by Attain and as such is not reflected in the table above.
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 2017/18.

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

2.145 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.

Pension benefits as at 31 March 2018

Name	Title	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at Pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash equivalent transfer value at 1 April 2017	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2018	Employer's contribution to partnership pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Slack	Managing Director	0-2.5	0-2.5	40-45	130-135	872	22	941	0
Alison Henly	Chief Finance Officer and Director of Performance	0-2.5	0	35-40	85-90	501	49	555	0
Paul Goodwin	Director of Commissioning and Governance	0-2.5	0-2.5	40-45	125-130	785	56	855	0
Sandra Corry	Director of Quality, Safety and Engagement	2.5-5	7.5-10	35-40	105-110	655	94	755	0
Rosie Benneyworth	Director of Strategic Clinical Services Transformation	0-2.5	0-2.5	10-15	20-25	99	19	143	0
Edward Ford	Chair	0-2.5	0	0-5	0	20	20	41	0
Will Harris	COG Chair	0-2.5	5-7.5	10-15	30-35	107	30	169	0
Alex Murray	COG Chair	5-7.5	10-12.5	10-15	30-35	108	84	208	0
Deborah Rigby	Acting Director of Quality, Safety and Engagement	0-2.5	2.5-5	25-30	85-90	561	49	655	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.

Cash equivalent transfer values

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

2.147 A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

2.148 The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

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

Compensation on early retirement of for loss of office

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

Payments to past members

2.151 The Clinical Commissioning Group has made no payments to past directors during 2017/18.

Pay multiples

2.152 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.

2.153 The banded remuneration of the highest paid member of the Governing Body in NHS Somerset CCG in the financial year 2017/18 was £156,000 (2016/17: £127,500). This was 4.6 times (2016/17: 3.80) the median remuneration of the workforce, which was £33,895 (2016/17: £33,560). The CCG appointed a new Chief Officer during 2017/18 which has resulted in an increase in the highest paid member of the Governing Body, increasing the pay multiple

2.154 In 2017/18, zero employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £10,796 to £156,000 (2016/17: £13,099 to £127,500).

2.155 There were no exit package paid in 2017/18.

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

2.157 The in housing of the Continuing Healthcare Assessment Team in March 2017 has had an effect on the median and pay multiple.

2.158 The remuneration report and notes on pages 123-134 has been audited by Grant Thornton UK LLP, Somerset CCG's external auditors.

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 2017 to 31 March 2018.
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	The amount that the Clinical Commissioning Group has contributed to individual's stakeholder pension schemes.

stakeholder pension	
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 2018	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 2018
Real increase in CETV	This reflects the increase in CETV effectively funded by the employer. It does not include 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 2018	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 2018

Remuneration of the Managing Director and Directors

2.159 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.

2.160 The membership and attendance at the Somerset CCG Remuneration Committee during 2017/18 is set out below:

Somerset CCG Remuneration Committee Meetings 2017/18 Attendance Record

✓ = Present X = Apologies Given V = voting NV = non-voting	25.05.17	14.07.17	14.09.17	14.12.17	02.03.18 (Telecon)
Lou Evans (V) Remuneration Committee Chair, and CCG Vice Chair and Non-Executive Director,	✓	✓	✓	✓	✓

✓ = Present X = Apologies Given V = voting NV = non-voting	25.05.17	14.07.17	14.09.17	14.12.17	02.03.18 (Telecon)
Governance and Audit					
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	X	✓	✓	✓
David Heath (V) Non-Executive Director, Patient and Public Engagement	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	✓	✓	✓	✓	✓
Nick Robinson (NV) Chief Officer with effect from August 2017			✓	✓	X
David Slack (NV) Managing Director/Accountable Officer to August 2017	✓	✓			
Note: 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 2017/18 and future years

2.161 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.

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

Policy on Contracts

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

Staff Report

Number of senior managers

2.164 The number of very senior managers is set out below in paragraph 2.168.

Staff numbers and costs

2.165 The Somerset CCG's total staff costs for the year ended 31 March 2018 are summarised in the following table: Table to updated SS

	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
	N4A	N4B	N4C	N4D	N4E	N4F	N4G	N4H	N4I
Salaries and wages	5,486	179	5,665	1,810	7	1,818	7,296	186	7,482
Social security costs	582	0	582	162	0	162	744	0	744
Employer contributions to the NHS Pension Scheme	701	0	701	197	0	197	899	0	899
Other pension costs	0	0	0	1	0	1	1	0	1
Apprenticeship levy	21	0	21	0	0	0	21	0	21
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	0	0	0	0	0	0	0	0	0
Gross Employee Benefits Expenditure	**6,791**	**179**	**6,969**	**2,170**	**7**	**2,177**	**8,960**	**186**	**9,147**
Less: Recoveries in respect of employee benefits (note 4.1.2)	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure including capitalised costs	**6,791**	**179**	**6,969**	**2,170**	**7**	**2,177**	**8,960**	**186**	**9,147**

Less: Employee costs capitalised	0	0	0	0	0	0	0	0	0
Net employee benefits expenditure excluding capitalised costs	**6,791**	**179**	**6,969**	**2,170**	**7**	**2,177**	**8,960**	**186**	**9,147**

Average Number of Persons Employed

2.166 The average number of Clinical Commissioning Group staff employed by staff grouping are as follows: Table to be updated

4.2 Average number of people employed			2017/18	2016/17
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	5	0	5	5
Administration and estates	119	3	122	114
Nursing, midwifery and health visiting staff	40	0	40	15
Scientific, therapeutic and technical staff	4	0	4	3
Social Care Staff	1	0	1	0
Total	**169**	**3**	**172**	137
Of the above:				
Number of whole time equivalent people engaged on capital projects	**-**	-	-	-

2.167 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. The increase in Nursing, midwifery and health visiting staff relates to the in housing of the Continuing Health Care team in March 2017

Staff composition Table to be updated

2.168 The breakdown of the gender profile for the CCG as at the end of March 2018 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	60%	40%	10 (2 vacancies)
Membership Body Clinical Operations Group Voting Members	36%	64%	14
Very Senior Managers	25%	75%	4
All substantive CCG Staff	22%	78%	225

Sickness absence data Figures provided by DH in May

Staff sickness absence and ill health retirements	2017-18 Number	2016-17 Number
Total Days Lost	**1,038**	340
Total Staff Years	**161**	126
Average working Days Lost	**6.5**	2.7

2.169 2017/18 staff sickness values are based on a 12 month period covering the calendar year of 2017. 2016/17 staff sickness values are based on a 12 month period covering the calendar year of 2016.

2.170 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.

Staff Policies

2.171 The Clinical Commissioning Group has applied the Health Problems and Disability in Employment policy in 2017/18.

Expenditure on consultancy

2.172 The Clinical Commissioning Group consultancy expenditure in 2017/18 was £820,000 (2016/17 £594,000), as per note 5 in the annual accounts.

Off-payroll engagements

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

Table 1: Off-payroll engagements longer than 6 months

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

2.174 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.

Table 2: New off-payroll engagements

2.175 For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than 6 months.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 To be added in table	1
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	1
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance	0

purposes during the year	
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll engagements / senior official engagements

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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total no. 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 should include both on payroll and off-payroll engagements.	13

2.177 Somerset Clinical Commissioning Group had no exit packages in 2017/18

Parliamentary Accountability and Audit Report

2.178 NHS Somerset CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at **Appendix A**. An audit certificate and report is also included in this Annual Report at **Appendix B (to be added to final version)**.

NHS Somerset Clinical Commissioning Group - Final Annual Accounts 2017-18

Entity name:	**NHS Somerset Clinical Commissioning Group**
This year	2017-18
Last year	2016-17
This year ended	31-March-2018
Last year ended	31-March-2017
This year commencing:	01-April-2017
Last year commencing:	01-April-2016

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

	Note	2017-18 £'000	2016-17 £'000
Income from sale of goods and services	2	(2,480)	(2,000)
Other operating income	2	(4,374)	(1,058)
Total operating income		**(6,854)**	**(3,058)**
Staff costs	4	9,147	7,454
Purchase of goods and services	5	734,029	721,065
Depreciation and impairment charges	5	88	78
Provision expense	5	225	358
Other Operating Expenditure	5	477	603
Total operating expenditure		**743,966**	**729,558**
Net Operating Expenditure		**737,112**	**726,500**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**737,112**	**726,500**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**737,112**	**726,500**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		0	0
Net (gain)/loss on revaluation of Intangibles		0	0
Net (gain)/loss on revaluation of Financial Assets		0	0
Actuarial (gain)/loss in pension schemes		0	0
Impairments and reversals taken to Revaluation Reserve		0	0
Items that may be reclassified to Net Operating Costs		0	0
Net gain/loss on revaluation of available for sale financial assets		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Sub total		0	0
Comprehensive Expenditure for the year ended 31 March 2018		**737,112**	**726,500**

The notes on pages 5 to 34 form part of this statement

Statement of Financial Position as at 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Non-current assets:			
Property, plant and equipment	13	321	370
Intangible assets	14	9	13
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		330	383
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	7,625	7,684
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	71	49
Total current assets		**7,698**	7,735
Non-current assets held for sale	21	0	0
Total current assets		**7,698**	7,735
Total assets		**8,028**	8,118
Current liabilities			
Trade and other payables	23	(45,303)	(37,178)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(722)	(779)
Total current liabilities		**(46,025)**	(37,957)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(37,997)**	(29,839)
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		**(37,997)**	(29,839)
Financed by Taxpayers' Equity			
General fund		(37,997)	(29,839)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(37,997)**	(29,839)

The notes on pages 5 to 34 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 24 May 2018 and signed on its behalf by:

Nick Robinson
Accountable Officer
NHS Somerset Clinical Commissioning Group

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(29,839)	0	0	**(29,839)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(29,839)**	**0**	**0**	**(29,839)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating expenditure for the financial year	(737,112)			(737,112)
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	**(737,112)**	**0**	**0**	**(737,112)**
Net funding	728,954	0	0	728,954
Balance at 31 March 2018	**(37,997)**	**0**	**0**	**(37,997)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2016-17				
Balance at 01 April 2016	**(24,957)**	**0**	**0**	**(24,957)**
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 31 March 2017	**(24,957)**	**0**	**0**	**(24,957)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2016-17				
Net operating costs for the financial year	(726,500)			(726,500)
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	**(726,500)**	**0**	**0**	**(726,500)**
Net funding	721,618	0	0	721,618
Balance at 31 March 2017	**(29,839)**	**0**	**0**	**(29,839)**

The notes on pages 5 to 34 form part of this statement

Statement of Cash Flows for the year ended 31 March 2018

	Note	2017-18 £'000	2016-17 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(737,112)	(726,500)
Depreciation and amortisation	5	88	78
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	0
(Increase)/decrease in trade & other receivables	17	59	(2,197)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	8,125	7,433
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(282)	(489)
Increase/(decrease) in provisions	30	225	358
Net Cash Inflow (Outflow) from Operating Activities		**(728,897)**	(721,317)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(35)	(302)
(Payments) for intangible assets		0	0
(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		**(35)**	(302)
Net Cash Inflow (Outflow) before Financing		**(728,932)**	(721,619)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		728,954	721,618
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		**728,954**	721,618
Net Increase (Decrease) in Cash & Cash Equivalents	20	**22**	(1)
Cash & Cash Equivalents at the Beginning of the Financial Year		**49**	50
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		**71**	49

The notes on pages 5 to 34 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2017-18 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on the going concern basis. 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 Clinical Commissioning Group has considered forecasts and budgets, timing of cash flows, contingent liabilities, financial and operational risk management, financial adaptability and other documentation provided to its Governing Body when assessing its going concern status.

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 and Social Care 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 and Social Care 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.

The Clinical Commissioning Group has entered into 4 pooled budgets with Somerset County Council. Under the arrangements, funds are pooled under Section 75 of the NHS Act 2006 for integrated community equipment, learning disability, carers services and the Better Care Fund. A memorandum note to the accounts provides details of the joint income and expenditure.

The pooled budgets for integrated community equipment, learning disability and carers servicesis are 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 2018 – 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.

Notes to the financial statements

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State for Health, 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 NHS 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.

Notes to the financial statements

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

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

1.14 **Donated Assets**

Somerset Clinical Commissioning Group does not have any Donated Assets

1.15 **Government Grants**

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

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

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.

1.18 **Private Finance Initiative Transactions**

Somerset Clinical Commissioning Group does not have any PFI schemes.

1.19 **Inventories**

Inventories are valued at the lower of cost and net realisable value.

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 2.42% (previously: minus 2.70%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.85% (previously: minus 1.95%)
- Timing of cash flows (over 10 years): Minus 1.56% (previously: minus 0.80%)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 **Clinical Negligence Costs**

The NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Resolution which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Resolution 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 Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 **Continuing healthcare risk pooling**

In 2014-15 a risk pool scheme was been introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. From 2017-18 the Clinical Commissioning Group no longer contribute to this risk pool.

1.25 **Carbon Reduction Commitment Scheme**

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

Notes to the financial statements

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.

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.

1.27.1 **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.

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.

In the year ended 31 March 2018, there were no financial liabilities held at fair value.

1.28.1 **Other Financial Liabilities**

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

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. Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

1.31 **Third Party Assets**

Somerset 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**

Somerset Clinical Commissioning Group does not have any Subsidiaries.

1.34 **Associates**

Somerset Clinical Commissioning Group does not have any Associates.

1.35 **Joint Ventures**

Somerset Clinical Commissioning Group does not have any Joint Ventures.

1.36 **Joint Operations**

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

- IFRS 9: Financial Instruments (application from 1 January 2018)
- IFRS 14: Regulatory Deferral Accounts (not applicable to DH groups bodies)
- IFRS 15: Revenue for Contract with Customers (application from 1 January 2018)
- IFRS 16: Leases (application from 1 January 2019)
- IFRS 17: Insurance Contracts (application from 1 January 2021)
- IFRIC 22: Foreign Currency Transactions and Advance Consideration (application from 1 January 2018)
- IFRIC 23: Uncertainty over Income Tax Treatments (application from 1 January 2019)

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

2 Other Operating Revenue

	2017-18 Total £'000	2016-17 Total £'000
Recoveries in respect of employee benefits	0	0
Patient transport services	0	0
Prescription fees and charges	0	0
Dental fees and charges	0	0
Education, training and research	871	11
Charitable and other contributions to revenue expenditure: NHS	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies	1,608	1,989
Continuing Health Care risk pool contributions	0	0
Income generation	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Non cash apprenticeship training grants revenue	2	0
Other revenue	4,373	1,058
Total other operating revenue	**6,854**	**3,058**

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

	2017-18 Total £'000	2016-17 Total £'000
From rendering of services	6,854	3,058
From sale of goods	0	0
Total	**6,854**	**3,058**

Revenue is totally from the supply of services. The Clinical Commissioning Group does not receive any revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

2017-18	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	7,482	7,296	186
Social security costs	744	744	0
Employer Contributions to NHS Pension scheme	899	899	0
Other pension costs	1	1	0
Apprenticeship Levy	21	21	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Gross employee benefits expenditure	**9,147**	**8,961**	**186**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**9,147**	**8,961**	**186**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**9,147**	**8,961**	**186**

4.1.1 Employee benefits

2016-17	Total	Permanent Employees	Other
	£'000	£'000	£'000
Employee Benefits			
Salaries and wages	6,067	5,979	88
Social security costs	631	631	0
Employer Contributions to NHS Pension scheme	745	745	0
Other pension costs	0	0	0
Apprenticeship Levy	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	11	11	0
Gross employee benefits expenditure	**7,454**	**7,366**	**88**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**7,454**	**7,366**	**88**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**7,454**	**7,366**	**88**

4.1.2 Recoveries in respect of employee benefits

2017-18	Total	Permanent Employees	Other	2016-17 Total
	£'000	£'000	£'000	£'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

	2017-18			2016-17
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**172**	**169**	**3**	**137**
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

	2017-18 Number	2016-17 Number
Total Days Lost	1,038	340
Total Staff Years	161	126
Average working Days Lost	6.5	2.7

	2017-18 Number	2016-17 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 2018.

4.4 Exit packages agreed in the financial year

	2017-18 Compulsory redundancies		2017-18 Other agreed departures		2017-18 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£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	0	0	0	0	0	0
£150,001 to £200,000	0	0	0	0	0	0
Over £200,001	0	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**	**0**

	2016-17 Compulsory redundancies		2016-17 Other agreed departures		2016-17 Total	
	Number	£	Number	£	Number	£
Less than £10,000	0	0	0	0	0	0
£10,001 to £25,000	0	0	1	11,221	1	11,221
£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**	**1**	**11,221**	**1**	**11,221**

	2017-18 Departures where special payments have been made		2016-17 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

	2017-18 Other agreed departures		2016-17 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	0	0	1	11,221
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HM Treasury approval*	0	0	0	0
Total	**0**	**0**	**1**	**11,221**

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

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

4.5 Pension costs

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

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

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

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

4.5.1 Accounting valuation

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

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2017-18, employers’ contributions of £894,552 were payable to the NHS Pensions Scheme (2016-17: £754,234) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme’s actuary reviews employer contributions, usually every four years and now based on HM Treasury Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2012. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2017-18 Total £'000	2016-17 Total £'000
Gross employee benefits		
Employee benefits excluding governing body members	8,457	6,777
Executive governing body members	690	677
Total gross employee benefits	**9,147**	**7,454**
Other costs		
Services from other CCGs and NHS England	3,840	3,445
Services from foundation trusts	487,777	471,385
Services from other NHS trusts	24,859	25,020
Sustainability Transformation Fund	0	0
Services from other WGA bodies	35	24
Purchase of healthcare from non-NHS bodies [1]	87,214	95,768
Purchase of social care	33,291	31,176
Chair and Non Executive Members	185	252
Supplies and services – clinical	0	0
Supplies and services – general	1,519	2,481
Consultancy services	820	594
Establishment	524	242
Transport	2,467	2,256
Premises	682	877
Impairments and reversals of receivables	0	0
Inventories written down and consumed	0	0
Depreciation	84	74
Amortisation	4	4
Impairments and reversals of property, plant and equipment	0	0
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets		
· Assets carried at amortised cost	0	0
· Assets carried at cost	0	0
· Available for sale financial assets	0	0
Impairments and reversals of non-current assets held for sale	0	0
Impairments and reversals of investment properties	0	0
Audit fees [3]	63	86
Other non statutory audit expenditure		
· Internal audit services	0	0
· Other services	0	0
General dental services and personal dental services	0	0
Prescribing costs	81,040	80,513
Pharmaceutical services	0	0
General ophthalmic services	545	475
GPMS/APMS and PCTMS	8,109	5,779
Other professional fees excl. audit [2]	50	180
Legal fees	166	24
Grants to Other bodies	260	323
Clinical negligence	7	8
Research and development (excluding staff costs)	25	20
Education and training	1,026	293
Change in discount rate	0	0
Provisions	225	358
Funding to group bodies	0	0
CHC Risk Pool contributions	0	447
Non cash apprenticeship training grants	2	0
Other expenditure	0	0
Total other costs	**734,819**	**722,104**
Total operating expenses	**743,966**	**729,558**

Notes

1. 2016-17 Purchase of healthcare from non-NHS bodies (£31,176,000) now within Purchase of Social Care following clarification of guidance from NHS England
2. 2016-17 Other professional fees excl. audit (£24,000) now within Legal fees following clarification of guidance from NHS England
3. External Audit Fees Net of Vat total £52,500
4. The auditor's liability for external audit work carried out for the financial year 2017/18 is limited to £2,000,000.

6.1 Better Payment Practice Code

Measure of compliance	**2017-18 Number**	**2017-18 £'000**	2016-17 **Number**	2016-17 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	12,272	124,745	20,076	124,357
Total Non-NHS Trade Invoices paid within target	12,248	124,265	20,026	124,242
Percentage of Non-NHS Trade invoices paid within target	**99.80%**	**99.62%**	**99.75%**	**99.91%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,396	512,129	3,617	499,887
Total NHS Trade Invoices Paid within target	3,387	511,760	3,604	499,860
Percentage of NHS Trade Invoices paid within target	**99.73%**	**99.93%**	**99.64%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2017-18 £'000**	2016-17 £'000
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	**0**	**0**

7 Income Generation Activities

The Clinical Commissioning Group did not have any income generation activities in 2017-18.

8. Investment revenue

The Clinical Commissioning Group did not have any Investment Revenue as at 31 March 2018.

9. Other gains and losses

The Clinical Commissioning Group did not have any other gains and losses as at 31 March 2018.

10. Finance costs

The Clinical Commissioning Group did not have any Finance Costs as at 31 March 2018.

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

The Clinical Commissioning Group have not transferred any function(s) that gave rise to any recognised gain or loss as at 31 March 2018.

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Services Ltd. In 2017-18, 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. This is reflected in Note 12.1.1.

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

	2017-18				2016-17			
	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	666	24	**690**	0	824	24	**848**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**666**	**24**	**690**	**0**	**824**	**24**	**848**

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

12.1.2 Future minimum lease payments

	2017-18				2016-17			
	Land £'000	**Buildings £'000**	**Other £'000**	**Total £'000**	**Land £'000**	**Buildings £'000**	**Other £'000**	**Total £'000**
Payable:								
No later than one year	0	0	20	**20**	0	0	20	**20**
Between one and five years	0	0	6	**6**	0	0	12	**12**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**26**	**26**	**0**	**0**	**32**	**32**

12.2 As lessor

The Clinical Commissioning Group did not have any leases let as at 31 March 2018.

13 Property, plant and equipment

2017-18	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 2017	0	0	0	0	0	0	475	114	589
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	30	5	35
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**505**	**119**	**624**
Depreciation 01 April 2017	0	0	0	0	0	0	201	18	219
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	69	15	84
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**270**	**33**	**303**
Net Book Value at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**235**	**86**	**321**
Purchased	0	0	0	0	0	0	235	86	321
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**235**	**86**	**321**
Asset financing:									
Owned	0	0	0	0	0	0	235	86	321
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**235**	**86**	**321**

Revaluation Reserve Balance for Property, Plant & Equipment

The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2018.

13 Property, plant and equipment cont'd

13.1 Additions to assets under construction
The Clinical Commissioning Group has no additions to assets under construction at 31 March 2018.

13.2 Donated assets
The Clinical Commissioning Group did not hold any donated assets at 31 March 2018.

13.3 Government granted assets
The Clinical Commissioning Group did not hold any government granted assets at 31 March 2018.

13.4 Property revaluation
The Clinical Commissioning Group did not have any property revaluation at 31 March 2018.

13.5 Compensation from third parties
The Clinical Commissioning Group did not have any compensation from third parties for assets impaired, lost or given up at 31 March 2018.

13.6 Write downs to recoverable amount
The Clinical Commissioning Group did not have any assets written down to recoverable amounts at 31 March 2018.

13.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2018.

13.8 Cost or valuation of fully depreciated assets
The Clinical Commissioning Group did not have any fully depreciated assets with any value still in use as at 31 March 2018.

13.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Buildings excluding dwellings	0	0
Dwellings	0	0
Plant & machinery	0	0
Transport equipment	0	0
Information technology	5	7
Furniture & fittings	7	10

14 Intangible non-current assets

2017-18	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 2017	20	0	0	0	0	20
Additions purchased	0	0	0	0	0	0
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 2018	**20**	**0**	**0**	**0**	**0**	**20**
Amortisation 01 April 2017	7	0	0	0	0	7
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	4	0	0	0	0	4
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 2018	**11**	**0**	**0**	**0**	**0**	**11**
Net Book Value at 31 March 2018	**9**	**0**	**0**	**0**	**0**	**9**
Purchased	9	0	0	0	0	9
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2018	**9**	**0**	**0**	**0**	**0**	**9**

Revaluation Reserve Balance for intangible assets
The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2018.

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 2018.

14.2 Government granted assets
The Clinical Commissioning Group did not hold any intangible non-current government granted assets at 31 March 2018.

14.3 Revaluation
The Clinical Commissioning Group did not have a revaluation at 31 March 2018.

14.4 Compensation from third parties

The Clinical Commissioning Group did not have any compensation from third parties for intangible non-current assets impaired, lost or given up at 31 March 2018.

14.5 Write downs to recoverable amount
The Clinical Commissioning Group did not have any intangible non-current assets written down to recoverable amounts at 31 March 2018.

14.6 Non-capitalised assets

The Clinical Commissioning Group did not have any significant intangible non-current assets not recognised as assets because they didn't meet the recognition criteria of IAS38 as at 31 March 2018.

14.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2018.

14.8 Cost or valuation of fully amortised assets
The Clinical Commissioning Group did not have any fully amortised assets still in use as at 31 March 2018.

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Computer software: purchased	5	5
Computer software: internally generated	0	0
Licences & trademarks	0	0
Patents	0	0
Development expenditure (internally generated)	0	0

15 Investment property

The Clinical Commissioning Group did not have any investment property as at 31 March 2018.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2017	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
Balance at 31 March 2018	**0**	**0**	**2**	**0**	**0**	**0**	**2**

17 Trade and other receivables	**Current 2017-18 £'000**	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'000
NHS receivables: Revenue	3,178	0	3,128	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	2,188	0	2,177	0
NHS accrued income	0	0	138	0
Non-NHS and Other WGA receivables: Revenue	1,227	0	616	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	769	0	854	0
Non-NHS and Other WGA accrued income	135	0	104	0
Provision for the impairment of receivables	0	0	0	0
VAT	128	0	667	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 and accruals	0	0	0	0
Total Trade & other receivables	**7,625**	**0**	**7,684**	**0**
Total current and non current	**7,625**		**7,684**	
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	**2017-18 £'000 DH Group Bodies**	**2017-18 £'000 Non DH Group Bodies**	2016-17 £'000 All receivables prior years
By up to three months	925	429	1,242
By three to six months	47	663	139
By more than six months	0	107	192
Total	**972**	**1,199**	**1,573**

£269,849 of the amount above has subsequently been recovered post the statement of financial position date.

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

	2017-18 £'000	2016-17 £'000
Receivables are provided against at the following rates:		
NHS debt	0	0

18 Other financial assets
The Clinical Commissioning Group did not have any other financial assets as at 31 March 2018.

19 Other current assets
The Clinical Commissioning Group did not have any other current assets as at 31 March 2018.

20 Cash and cash equivalents

	2017-18 £'000	2016-17 £'000
Balance at 01 April 2017	49	50
Net change in year	22	(1)
Balance at 31 March 2018	**71**	**49**
Made up of:		
Cash with the Government Banking Service	71	49
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	**71**	**49**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2018	**71**	**49**
Patients' money held by the Clinical Commissioning Group, not included above	0	0

21 Non-current assets held for sale
The Clinical Commissioning Group did not have any non-current assets held for sale as at 31 March 2018.

22 Analysis of impairments and reversals
The Clinical Commissioning Group did not make any impairments in 2017-18

23 Trade and other payables	Current 2017-18 £'000	Non-current 2017-18 £'000	Current 2016-17 £'000	Non-current 2016-17 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,945	0	2,532	0
NHS payables: capital	0	0	0	0
NHS accruals	6,274	0	1,453	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	4,489	0	7,687	0
Non-NHS and Other WGA payables: Capital	0	0	0	0
Non-NHS and Other WGA accruals	30,600	0	24,527	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	113	0	99	0
VAT	0	0	0	0
Tax	95	0	82	0
Payments received on account	0	0	0	0
Other payables and accruals	787	0	798	0
Total Trade & Other Payables	**45,303**	**0**	**37,178**	**0**
Total current and non-current	**45,303**		**37,178**	

Other payables include £137,538 outstanding pension contributions at 31 March 2018

24 Other financial liabilities
The Clinical Commissioning Group did not have any other financial liabilities as at 31 March 2018.

25 Other liabilities
The Clinical Commissioning Group did not have any other liabilities as at 31 March 2018.

26 Borrowings
The Clinical Commissioning Group did not have any borrowings as at 31 March 2018.

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 2018.

28 Finance lease obligations
The Clinical Commissioning Group did not have any finance lease obligations as at 31 March 2018.

29 Finance lease receivables
The Clinical Commissioning Group did not have any finance lease receivables as at 31 March 2018.

29.1 Finance leases as lessor
The Clinical Commissioning Group did not have any unguaranteed residual value accruing as at 31 March 2018.
The Clinical Commissioning Group did not have any accumulated allowance for uncollectible lease receivables as at 31 March 2018.

30 Provisions

	Current 2017-18 £'000	**Non-current 2017-18 £'000**	Current 2016-17 £'000	Non-current 2016-17 £'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	722	0	597	0
Other	0	0	182	0
Total	**722**	**0**	**779**	**0**
Total current and non-current	**722**		**779**	

	Pensions Relating to Former Directors £'000	**Pensions Relating to Other Staff £'000**	**Restructuring £'000**	**Redundancy £'000**	**Agenda for Change £'000**	**Equal Pay £'000**	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**597**	**182**	**779**
Arising during the year	0	0	0	0	0	0	0	722	0	722
Utilised during the year	0	0	0	0	0	0	0	(282)	0	(282)
Reversed unused	0	0	0	0	0	0	0	(315)	(182)	(497)
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
Transfer (to) from other public sector body under absorption	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**722**	**0**	**722**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	722	0	722
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 2018	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**722**	**0**	**722**

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 Previously Unassessed Periods of Care NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2018 is £111k

The "Other" provision was a provision made by the Clinical Commissioning Group in 2016-17 in relation to a review being undertaken by Her Majesty Revenue and Customs. This investigation is now closed.

31 Contingencies

	2017-18 £'000	2016-17 £'000
Contingent liabilities		
Equal Pay	0	0
NHS Resolution Legal Claims	0	0
Employment Tribunal	0	0
NHS Resolution employee liability claim	0	0
Redundancy	0	0
Continuing Healthcare	189	140
Litigation	0	0
HM Revenue and Customs	0	32
Net value of contingent liabilities	**189**	**172**
Contingent assets		
Amounts recoverable against contingent liabilities	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group did not have any contracted capital commitments not otherwise included in these financial statements as at 31 March 2018.

32.2 Other financial commitments

The Clinical Commissioning Group did not have any non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) as at the 31 March 2018.

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 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 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. The Clinical Commissioning Group 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 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' 2017-18 £'000	**Loans and Receivables 2017-18 £'000**	**Available for Sale 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	3,179	0	3,179
· Non-NHS	0	1,361	0	1,361
Cash at bank and in hand	0	71	0	71
Other financial assets	0	0	0	0
Total at 31 March 2018	**0**	**4,611**	**0**	**4,611**

	At 'fair value through profit and loss' 2016-17 £'000	Loans and Receivables 2016-17 £'000	Available for Sale 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0	0
Receivables:				
· NHS	0	3,266	0	3,266
· Non-NHS	0	721	0	721
Cash at bank and in hand	0	49	0	49
Other financial assets	0	0	0	0
Total at 31 March 2017	**0**	**4,036**	**0**	**4,036**

33.3 Financial liabilities

	At 'fair value through profit and loss' 2017-18 £'000	**Other 2017-18 £'000**	**Total 2017-18 £'000**
Embedded derivatives	0	0	0
Payables:			
· NHS	0	9,219	9,219
· Non-NHS	0	35,876	35,876
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 2018	**0**	**45,095**	**45,095**

	At 'fair value through profit and loss' 2016-17 £'000	Other 2016-17 £'000	Total 2016-17 £'000
Embedded derivatives	0	0	0
Payables:			
· NHS	0	3,985	3,985
· Non-NHS	0	33,012	33,012
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 2017	**0**	**36,997**	**36,997**

Other Financial Instruments

The carrying amount of the following financial assets and liabilities is considered a reasonable approximation of fair value:
trade and other receivable
cash and cash equivalents
trade and other payables

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net liabilities £'000
NHS Somerset Clinical Commissioning Group	743,966	(6,854)	**737,112**	8,028	(46,025)	**(37,997)**
Total	**743,966**	**(6,854)**	**737,112**	**8,028**	**(46,025)**	**(37,997)**

34.1 Reconciliation between Operating Segments and SoCNE

	2017-18 £'000
Total net expenditure reported for operating segments	737,112
Total net expenditure per the Statement of Comprehensive Net Expenditure	**737,112**

34.2 Reconciliation between Operating Segments and SoFP

	2017-18 £'000
Total assets reported for operating segments	8,028
Total assets per Statement of Financial Position	**8,028**

	2017-18 £'000
Total liabilities reported for operating segments	(46,025)
Total liabilities per Statement of Financial Position	**(46,025)**

35 Pooled budgets

Integrated Community Equipment Service Pooled Fund

NHS Somerset Clinical Commissioning Group is party to an Integrated Community Equipment Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Community Equipment in Somerset.

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 equipment services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2017-18 £'000	2016-17 £'000
Income	0	0
Expenditure	(1,169)	(1,363)

Carers Services Pooled Fund

NHS Somerset Clinical Commissioning Group is party to a Carers Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Carers Services in Somerset.

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 Carers services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2017-18 £'000	2016-17 £'000
Income	0	0
Expenditure	(245)	(231)

Learning Disability Service Pooled Fund

NHS Somerset Clinical Commissioning Group is party to a Learning Disability Service pooled budget with Somerset County Council. Under this arrangement funds are pooled under s75 of the Health Act 2006 for the provision of Learning Disability Services in Somerset.

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 Learning Disability services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure as determined by the pooled budget agreement.

The Clinical Commissioning Group's share of the income and expenditure handled by the pooled budget in the financial year were as follows:

	2017-18 £'000	2016-17 £'000
Income	0	0
Expenditure	(21,546)	(19,519)

Better Care Fund

The Clinical Commissioning Group entered into a Better Care Fund partnership agreement under s75 of the Health Act 2006 with Somerset County Council on 1st April 2015.

As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pools, which are then used to purchase health and social care 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 agreement.

The Clinical Commissioning Group's share of expenditure for each pooled budget area within the Better Care Fund in the financial year were as follows:

	2017-18	2016-17
	£'000	£'000
Income	0	0
Expenditure	(35,639) *	(35,010) *

* Less (£203,500) included within Carers Pooled Budget figure above

36 NHS Lift investments

The Clinical Commissioning Group did not have any NHS LIFT investments as at 31 March 2018.

37 Related party transactions

Details of related party transactions with individuals are as follows:

31 March 2018	**Payments to Related Party £ '000**	**Receipts from Related Party £ '000**	**Amounts owed to Related Party £ '000**	**Amounts due from Related Party £ '000**
Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care David Bell 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	0	0	0	0
Yeovil Town Football Club	0	0	0	0
Yeovil Town Holdings Limited	0	0	0	0
Non-Executive Director and Registered Nurse Dr Jayne Chidgey-Clark is a director of JCC Partnership Limited and a Clinical Associate for the NHS England New Care Models Programme. Her spouse is a director and company secretary of JCC Partnership Limited and Director of Nursing and Quality at NHS North Somerset Clinical Commissioning Group **(withdrawn 25/01/18)**, managing director of Thera South West **(added 25/01/18)** and her daughter is an employee of PricewaterhouseCoopers. Jayne Chidgey-Clark is the CCG nominated Governor of Somerset Partnership NHS Foundation Trust				
JCC Partnership Limited	0	0	0	0
NHS England	11	418	1	841
NHS North Somerset Clinical Commissioning Group **(withdrawn 25/01/18)**	0	0	0	0
PricewaterhouseCoopers LLP	9	0	0	0
Somerset Partnership NHS Foundation Trust	132,689	1,450	404	762
Thera South West, part of Thera Trust **(added 25/01/18)**	0	0	0	0
Vice Chair and Non Executive Director Lou Evans is a director at Martin Brooks Associates Limited, 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, and is National Advisor to GPiC Ltd **(added 25/01/18)** His wife is employed as an Occupational Therapist at Somerset Partnership NHS Foundation Trust **(withdrawn 25/05/17)**				
GPI Healthcare Property Solutions - **added 25/01/18**	0	0	0	0
Justice of the Peace Committee	0	0	0	0
Martin Brooks Associates Limited	0	0	0	0
Somerset Partnership NHS Foundation Trust - **withdrawn 25/05/17**	132,689	1,450	404	762
Yeovil District Hospital NHS Foundation Trust	85,760	743	833	961
Chair Dr Ed Ford is a GP Partner at Irnham Lodge Surgery, which is a training practice and member of West Somerset GP Commissioning Locality and a member of Somerset Primary Care Limited. Dr Ford is a CCG member of the Health and Wellbeing Board, West Somerset GP Commissioning Locality Chair, a first responder for Somerset Accident Voluntary Emergency Service, a Hospital Practitioner at Minehead Injury Unit (under contract to Somerset Partnership NHS Foundation Trust) (**withdrawn 14/09/17)**, works shifts in the 999 GP Project, and is co-chair of Severn Urgent and Emergency Care Network **(added 25/05/17, withdrawn 25/01/18).** His spouse is Lead Nurse for the Age UK 'Living Better Together' project based in West Somerset **(added 25/01/18, withdrawn 22/03/18)** then Community Development and Liaison Practitioner for Musgrove Park Hospital **(added 22/03/18).**				
Age UK - **added 25/01/18, withdrawn 22/03/18**	0	0	0	0
Irnham Lodge Surgery	136	0	31	0
Severn Urgent and Emergency Care Network - **added 25/05/17, withdrawn 25/01/18**	0	0	0	0
Somerset Accident Voluntary Emergency Service	0	0	0	0
Somerset Partnership NHS Foundation Trust - **withdrawn 14/09/17**	132,689	1,450	404	762
Somerset Primary Healthcare Limited	201	0	0	27
South Western Ambulance Service NHS Foundation Trust	21,522	0	103	0
Taunton & Somerset NHS Foundation Trust - **added 22/03/18**	196,913	1,032	2,261	2,523
West Somerset GP Commissioning Locality	0	0	0	0
Non-Executive Director and Secondary Care Doctor Basil Fozard has no interests to declare.				
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.				
Somerset Activity and Sports Partnership	0	0	0	0
Somerset County Council	36,057	1,536	3,076	1,131
GP Dr Will Harris **(resigned effective from 30/09/17)** is Chair of the Clinical Operations Group, COG delegate for West Mendip Commissioning Locality, a GP Partner at Wells Health Centre which is a member of West Mendip Commissioning Locality and a shareholder of Somerset Primary Healthcare Limited.				
Somerset Primary Healthcare Limited	201	0	0	27
The Human Five Ltd - **added 22/06/17**	0	0	0	0
Wells Health Centre	241	0	0	0
West Mendip Comissioning Locality	0	0	0	0

31 March 2018	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
Non Executive Director, Patient & Public Engagement David Heath **(appointed 01/06/17)** is Chair of Western Region and National Board Member of the Consumer Council for Water, Board Member of the Solicitors Regulation Authority **(removed 22/03/18)**, Senior Independent Director for the Solicitors Regulation Authority **(added 22/03/18**) and Non-executive director of Bath and Wells Multi-academy trust				
Bath and Wells Multi-Academy Trust	0	0	0	0
Consumer Council for Water	0	0	0	0
Solicitors Regulation Authority	0	0	0	0
Chief Finance Officer and Director of Performance Alison Henly has no interests to declare.				
Governing Body GP **(added 22/06/17)** and COG Chair **(appointed 01/10/17)** Dr Alex Murray is Bridgwater Bay Health Commissioning Locality Delegate, GP Partner at East Quay Medical Centre Bridgwater which is a shareholder in Somerset Primary Healthcare Ltd, and is director and shareholder of both East Quay Health Ltd and East Quay Vision Ltd.				
Bridgwater Bay Commissioning Locality	23	0	0	0
East Quay Health Ltd	34	0	0	0
East Quay Medical Centre	167	17	0	0
East Quay Vision Ltd	57	0	0	0
Somerset Primary Healthcare Limited	201	0	0	27
Chief Officer (**appointed 14/08/17**) Nick Robinson is managing director of Nick Robinson Consulting Ltd (not currently trading) which provides consultancy, financial and interim management support to NHS organisations. His spouse is employed as a Specialist Community Dietician by Essex Partnership University NHS Foundation Trust.				
Essex Partnership University NHS Foundation Trust	6	0	4	0
Nick Robinson Consulting Ltd	0	0	0	0
Managing Director / Accountable Officer David Slack **(resigned effective from 14/08/17)** 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 and as a bank healthcare assistant by Taunton & Somerset NHS Foundation Trust, his daughter-in-law is a GP trainee at Severn Deanery				
Severn Deanery	0	0	0	0
Somerset County Council	36,057	1,536	3,076	1,131
Taunton & Somerset NHS Foundation Trust	196,913	1,032	2,261	2,523
Director of Strategic Clinical Services Transformation Dr Rosie Benneyworth **(appointed 23/10/17)** is a Board Trustee at Nuffield Trust and Vice Chair/Non-Executive Director at National Institute for Health and Care Excellence (NICE)				
National Institute for Health and Care Excellence (NICE)	0	0	0	0
Nuffield Trust	0	0	0	0
Director of Quality and Patient Safety Sandra Corry has a 5% share in her spouse's consultancy company QSI Limited which provides support to Health and Social Care sectors				
QSI Limited	0	0	0	0
Healthwatch Representative Judith Goodchild is a member of the Health and Wellbeing Board and Public Governor of Taunton & Somerset NHS Foundation Trust representing West Somerset				
Somerset County Council	36,057	1,536	3,076	1,131
Taunton & Somerset NHS Foundation Trust	196,913	1,032	2,261	2,523
Deputy Chief Officer and Director of Comissioning Reform Paul Goodwin **(updated 14/09/17)**, (previously Deputy Managing Director and Director of Commissioning and Governance) has a daughter-in-law who is an employee of PricewaterhouseCoopers LLP, and is the Clinical Commissioning Group's representative on the South West Academic Health Science Network Membership Council. Paul Goodwin was seconded from his substantive CCG role with effect from 23/02/18 to work for the BaNES, Swindon & Wiltshire STP.				
PricewaterhouseCoopers LLP	9	0	0	0
South West Academic Health Science Network	18	0	0	0
Temporary Healthwatch Representative Christine Graves **(added 14/12/17, removed 22/03/18)** is Chair of the Board of Directors of Evolving Communities has no interests to declare				
Acting Director of Quality and Patient Safety Deborah Rigby **(with effect from 01/09/17 to 31/03/18)** is registered as an independent specialist nurse and sees a small number of private patients at BMI Bath Clinic or Spire Bristol Clinic				
BMI Healthcare	675	0	0	0
Spire Healthcare	98	0	0	0
PPG Lay Observer Peter Rowe **(resigned effective from 01/08/17)** is a representative of the Somerset County Patient Participation Group Chairs Network				
County PPG Chairs' Group	0	0	0	0

31 March 2018	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
PPG Lay Observer Sandra Wilson **(added 14/09/17)** is chair of Somerset PPG Chairs Network, Chair of Exmoor Medical Centre PPG, Director of YLEM Ltd which supplies computer & IT Equipment and services, and IVT Technologies Ltd which supplies audio visuals goods and services				
County PPG Chairs' Group	0	0	0	0
Exmoor Medical Centre PPG	1,134	0	0	0
IVC Technologies Ltd	0	0	0	0
YLEM Ltd	0	0	0	0
Local Medical Committee Observer Dr Harry Yoxall **(Stepped down 22/02/18)** is the Medical Secretary of the Somerset Local Medical Committee and his wife is sessional GP in the Accident & Emergency department at Taunton & Somerset NHS Foundation Trust				
Somerset LMC	187	5	3	0
Taunton & Somerset NHS Foundation Trust	196,913	1,032	2,261	2,523

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 and Social Care 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 2018	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
NHS England	11	418	1	841
South, Central and West Commissioning Support	3,837	0	770	34
NHS FOUNDATION TRUSTS				
Dorset County Hospital NHS Foundation Trust	2,281	0	58	0
Essex Partnership University NHS Foundation Trust	6	0	4	0
Royal Brompton & Harefield NHS Foundation Trust	193	0	25	0
Royal Devon and Exeter NHS Foundation Trust	4,608	0	30	3
Royal United Hospital Bath NHS Foundation Trust	31,341	0	470	195
Salisbury NHS Foundation Trust	680	0	129	0
Somerset Partnership NHS Foundation Trust	132,689	1,450	404	762
South Western Ambulance Service NHS Foundation Trust	21,522	0	103	0
Taunton and Somerset NHS Foundation Trust	196,913	1,032	2,261	2,523
University Hospitals Bristol NHS Foundation Trust	8,116	0	482	4
Yeovil District Hospital NHS Foundation Trust	85,760	743	833	961
NHS TRUSTS				
North Bristol NHS Trust	7,213	0	323	0
Northern Devon Healthcare NHS Trust	491	0	0	38
Weston Area Health NHS Trust	14,604	0	732	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 Third party assets
The Clinical Commissioning Group held no third party assets as at 31 March 2018.

40 Financial performance targets

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

	2017-18 Target £'000	**2017-18 Performance £'000**	2016-17 Target £'000	2016-17 Performance £'000
Expenditure not to exceed income	743,426	743,966	726,542	729,558
Capital resource use does not exceed the amount specified in Directions	35	35	50	50
Revenue resource use does not exceed the amount specified in Directions	736,572	737,112	723,484	726,500
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	0	0	0	0
Revenue administration resource use does not exceed the amount specified in Directions	11,882	10,992	11,873	11,108

Notes
2016-17 Expenditure not to exceed income restated to Gross Expenditure, from previous Target (£6.484m) and Performance (-£3.016m)
2016-17 Capital resource use on specified matter(s) does not exceed the amount specified in Directions, from previous Target (£50,000) and Performance (£50,000)
2016-17 Revenue resource use on specified matter(s) does not exceed the amount specified in Directions, from previous Target (£711.611m) and Performance (£715.392m)

41 Impact of IFRS
Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2017-18 financial year

42 Analysis of charitable reserves

	2017-18 £'000	2016-17 £'000
Unrestricted funds	0	0
Restricted funds	0	0
Endowment funds	0	0
Total	**0**	**0**

Independent auditor's report to the members of the Governing Body of NHS Somerset Clinical Commissioning Group

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Somerset Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012.

In our opinion the financial statements:

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

Basis for opinion

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

Who we are reporting to

This report is made solely to the members of the Governing Body of the CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

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

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

Other information

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

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

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Qualified opinion on regularity required by the Code of Audit Practice

In our opinion, except for the effects of the matter described in the basis for qualified opinion on regularity section of our report, 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.

Basis for qualified opinion on regularity

The CCG reported that its expenditure exceeded its income by £540,000 in its financial statements for the year ending 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223H of Section 27 of the Health and Social Care Act 2012, to ensure that its expenditure in a financial year does not exceed its income.

The CCG also reported a deficit of £540,000 against its in-year revenue resource limit in its financial statements for the year ending 31 March 2018, thereby breaching its duty under the National Health Service Act 2006, as amended by paragraph 223I of Section 27 of the Health and Social Care Act 2012, to ensure that its revenue resource use in a financial year does not exceed the amount specified by direction of the NHS Commissioning Board.

Matters on which we are required to report by exception

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

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30(a) of the Local Audit and Accountability Act 2014 because we had reason to believe that the CCG, or an officer of the CCG, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency, or
- we have made a written recommendation to the CCG under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 11 May 2018 we referred a matter to the Secretary of State under section 30(b) of the Local Audit and Accountability Act 2014 in relation to NHS Somerset CCG's breach of its revenue resource limit for the year ending 31 March 2018.

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

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

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

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

The Governing Body is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matter described in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, NHS Somerset Clinical Commissioning Group put in

place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matter:

NHS Somerset CCG has been issued with a performance rating of 'inadequate' by NHS England. The CCG has been in a reframed special measures regime since April 2017. The key areas of failure identified by NHS England were:

- insufficient progress has been made in respect of leading financial recovery for the CCG and for the Somerset health system
- there has been failure against some key performance measures
- the leadership's decision making ability has been weak.

This matter identifies significant weaknesses in the CCG's governance arrangements. This matter is evidence of weaknesses in proper arrangements for informed decision making in acting in the public interest, through demonstrating and applying the principles and values of sound governance.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Geraldine N Daly

Geraldine Daly
Associate Director
for and on behalf of Grant Thornton UK LLP

2 Glass Wharf, Temple Quay, Bristol. BS2 0EL

25 May 2018