NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2016/17

25 May 2017

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ANNUAL REPORT 2016/17

1 INTRODUCTION

As Chairman of Somerset Clinical Commissioning Group (CCG) it is once again my pleasure to highlight the achievements and challenges that the CCG and its GP members have experienced in 2016/17.

Patients in Somerset continue to receive good quality treatment and care and express high levels of satisfaction in their local GP, hospital and community health services. Friends and Family test ratings are consistently good amongst all three of the county's NHS Foundation Trusts and the annual GP patient survey shows overall patient satisfaction continues to be very high for most practices.

However, high levels of patient satisfaction belie the pressures that all parts of the local health and social services are currently experiencing.

Demand upon local health a services continues to rise each year particularly in urgent and emergency health care. I am pleased to report that despite the county's entire urgent care and social services experiencing exceptionally high demand last winter, the system managed well and even reduced the number of delayed patient discharges from hospital by almost 50%.

Somerset's health care system continues to struggle to recruit doctors, nurses, and therapists and this will take time to overcome. The demand upon General Practice and primary care services, as we move to seven day a week access for patients, will be a further test on the effectiveness of collaborative working. I am confident Somerset's 72 GP Practices will deliver the necessary improved access. Those most likely to benefit from extended access could be shift workers or those living with long-term health conditions.

This year, the chronic shortage of hospital dermatologists, led Taunton's Musgrove Park Hospital to stop accepting new patients with suspected skin cancer. Patients from the west of the county currently have to travel to hospital clinics in Bristol, Bath, Yeovil and Exeter for diagnosis and treatment. We are thankful for the support given to Somerset CCG by the many hospital Trusts who were able to offer Somerset dermatology patients their diagnosis and treatment but acknowledge the inconvenience that this has caused some patients. A solution has been found and a new dermatology service will be established at Musgrove Park Hospital, with the help of University Hospitals Bristol NHS Foundation Trust, in early 2018.

A national plan known as the 'Five Year Forward View', sets out the priorities for the NHS over the next five years. The leaders of Somerset's NHS Foundation Trusts, the Clinical Commissioning Group and the local

authority area are working in close collaboration to deliver these national policy objectives.

Known as the Sustainability and Transformation Plan (STP), it describes why we need to change the way health and social care services are structured and delivered in order to meet the future needs of the people of Somerset.

To be successful the plan will need to reduce demand for health care by preventing ill health and promoting healthy lifestyles; improve the quality and effectiveness of local health services with more care being delivered in the community or the patient's own home and address a predicted funding deficit which could amount to over £600 million by 2020 if we do nothing different.

New models of health care that focus upon people living with the most chronic ill health are being tested across the county. The South Somerset Symphony scheme continues to support hundreds of patients' living with long-term ill health conditions resulting in fewer patients becoming ill and needing to be admitted to district hospital. In East Mendip the introduction of 'Health Connectors' is providing people living with chronic ill health with a powerful way to network and support each other, also resulting in fewer admissions to hospital. Collaboration between the NHS, local authority and the voluntary sector is also proving particularly innovative in rural communities and many ways are being developed to support individual patients and their carers who may be elderly, disabled or experiencing social isolation.

Over £1 million was invested by Somerset CCG to enable the roll-out of the Somerset Early Supported Stroke Discharge scheme. The scheme is now operating across the county and is enabling more patients who have had a stroke to be discharged from hospital and have their rehabilitation provided in the comfort of their own home.

Further investment was made this year in the county's mental health services addressing the need for greater 'parity of esteem' between physical and mental health care. Almost £1 million has been directed to Child and Adolescent Mental Health Services, Eating Disorder Services and mental health crisis teams.

An essential element of Somerset's STP will be the gathering of views from patients, carers, community stakeholders, NHS staff, health professionals and the public. These views will be used to shape the plan and will be essential if we are to create more patient centred ways of delivering health care.

Somerset CCG has an annual budget of £750 million and this year has been the first occasion the CCG has experienced a budget deficit (approximately £3 million). This has been largely caused by the increased number of patients being seen and treated at the county's two district

hospitals. Somerset CCG is responsible for paying for people who are eligible to have their nursing home care funded under the NHS Funded Nursing Care scheme. A 40% increase in the cost of nursing home fees has also contributed to the budget overspend.

Although measures are planned to recover this financial deficit, the CCG faces a financial challenge of £15 million in the coming financial year (2017/18).

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 friendly 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.

2 PERFORMANCE REPORT

Review of CCG Business for 2016/17

2.1 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.

2.2 Somerset has on average a more elderly population than the South West region and England as a whole with more than one in five of the residents of the county being over 65 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.

2. 3 Somerset has a particular dip in the population of 20 to 40 year olds compared to England and Wales as a whole. We believe this is due to younger people leaving the county for university and/or jobs. The county has no large urban areas, or universities.

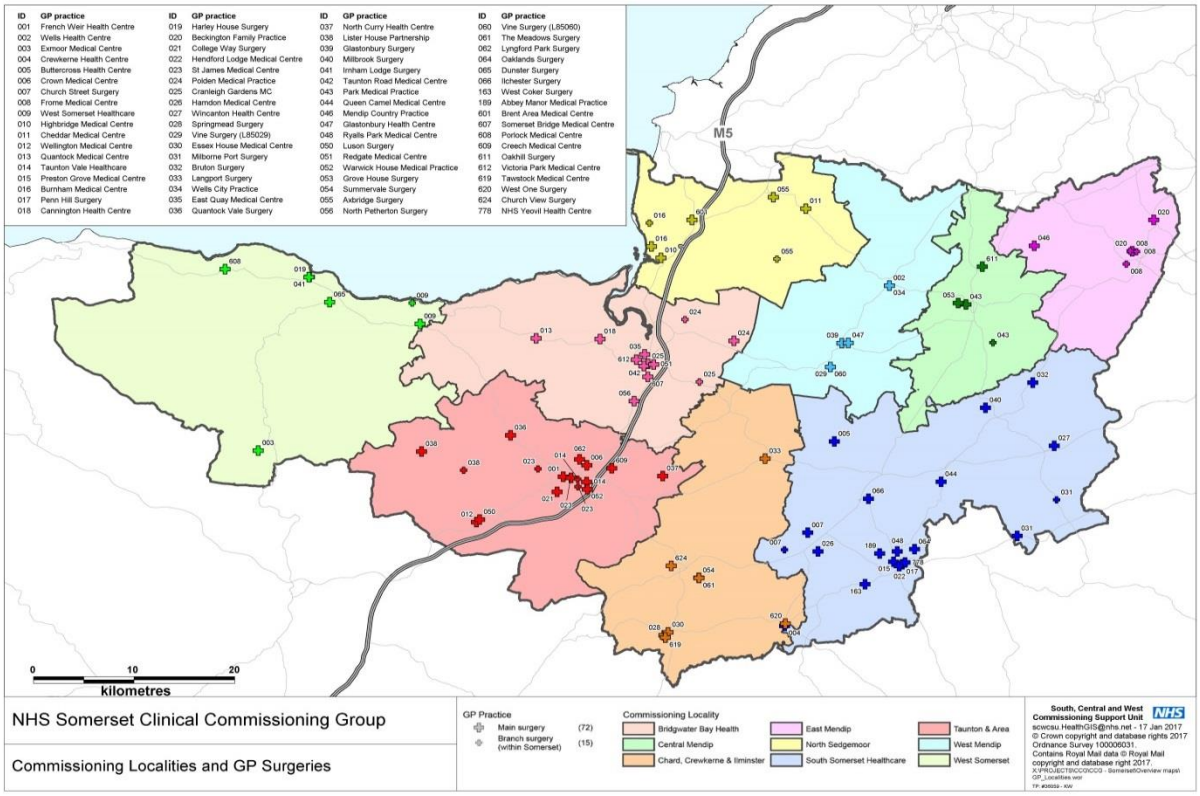
2.4 Overall life expectancy for Somerset residents is approximately two years higher than the national average. Over the past decade, death rates from all causes have decreased and those from coronary heart disease and cancer are lower than the national average. This demographic profile presents complex 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.

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

2.6 The profile of service provision across the county is:

- 234 community hospital beds open over 13 sites
- 852 general beds across 2 District General Hospitals (DGHs)
- 53 maternity beds
- 71 GP Practices across 9 localities (there were several Practice mergers which has reduced the total number from 75 in 2015/16)

2.7 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 71 Member Practices are located within the County Council boundary, and can align themselves to one of nine localities as depicted:



2.8 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.

2.9 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

2.10 Tackling health inequalities and being focused on advancing equality has been a key strategic aim of Somerset CCG during 2016/17 and the CCG Two Year Commissioning Plan for 2014/16 set out the priorities for delivering the strategy in the following six core work programmes:

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

2.11 In addition, the CCG has been working with partner organisations on the Somerset Together programme to introduce Outcome Based Commissioning 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 in 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.

2.12 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)

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

2.14 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.

2.15 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.

COLLABORATIVE WORKING

2.16 The focus for the Collaborative Working Programme has been the continuation of embedding person centred care as the way individual's experience their care and treatment across Somerset.

2.17 Somerset CCG has been delivering its person centred care programme, Somerset House of Care, since 2014, and has trained almost 300 people from 75% of GP Practices in personalised care and support planning. During that time we have seen a significant shift in the approach and skills

of clinicians in supporting self-management of people with long-term conditions. This education is considered by practitioners to be of a very high standard and beneficial and so this will continue into 2017/18.

2.18 Intelligence and insight gathered from the previous three years has provided a tailored package of support to GP Practices, and other members of the Somerset health community, ensuring that the core principles of care and support planning can be implemented and embedded in their organisations in an effective and sustainable way.

2.19 Three 'motivational interviewing' courses have been run to help practitioners better understand how to change the behaviours of people. It is 'a collaborative, goal-oriented style of communication with particular attention to the language of change and is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion' (S Rollnick PhD 2012). These courses have been well attended and further courses are planned for 2017/18.

2.20 The 13 step Patient Activation Measure (PAM) is continuing to be used to identify people who are at a low level of activation and in need of support and education to help them manage their conditions better, and who want to re-connect with the communities in which they live. The PAM is also used to measure the success of specific interventions in improving people's confidence, skills and understanding. More than 4,000 PAM surveys have now been completed and 40% of people were at the two lowest levels of activation. Of those who had also completed a second PAM after establishing what matters to them, and receiving health advice and help with community referrals, a large proportion have improved their activation scores and levels. A new more automated system which Practices can use for recording and scoring PAMs is being implemented across Somerset and this helps practitioners obtain more immediate results. In 2017/18 the PAM10 will be used which is shorter and clearer than the current version.

New Models of Care

2.21 During 2016/2017 the pilot 'New Models of Care' which the CCG supported last year in South Somerset, Taunton and Mendip further developed the range of the support they provide as well as their geographical scope.

2.22 These services (known locally as the "Test and Learns")

- supported more than 4,000 people with long term conditions (such as diabetes) to better access the kind of social support in their community , for example exercise and fitness programmes, that deliver long term health benefits- and make life more enjoyable

- provided more joined up medical, nursing care and therapy support for more than 1,000 people with multiple and more complex long term conditions.

2.23 The CCG, in partnership with the organisations delivering the Test and Learns, worked with the Academic Health Science Network to begin to evaluate the impact on the lives of people that used them, and on the need for other services. The final results are not yet available, but both patients and staff reported positively on their experience of these services and there is some emerging evidence that accessing this kind of support slows the growth in demand that most places in the country are experiencing. The pilot sites are working together to take the learning from each of these slightly different services and "build on the best".

Integrated Personal Commissioning (Personal Health Budgets)

2.24 Personal budgets have been in place for social care for a number of years, and are now being offered to small cohorts of people for some health related care through Personal Health Budgets (PHB). They are based on personalised care plans and are particularly helpful if traditional services are not achieving the outcomes of those plans. Any money allocated in a PHB can only be used for things in line with the personalised care plan and agreed with the relevant healthcare professional. Unlike social care personal budgets, PHBs are not means tested. Integrated Personal Commissioning (IPC) combines elements of both health and social care.

2.25 Work is focusing on developing this personalised budget offer for people with Continuing Healthcare (CHC) needs, adults with learning disabilities (LD) via Somerset County Council and people requiring wheelchairs. The total number of people offered a PHB by the end of December 2016 in Somerset was 2,961. However the vast majority of people who were offered the choice and control of a PHB to support their health needs chose not to take a direct payment but instead continue to use traditional services.

2.26 Somerset is developing plans to increase the number of people who benefit from IPC and is looking at creative and efficient ways of facilitating this in partnership with the local authority and other health, social, voluntary, community and other agencies.

Somerset Integrated Digital electronic Record (SIDeR)

2.27 Somerset CCG is working with all the key Somerset health and care providers to improve direct care to patients, by making the most of their Information Technology (IT) systems and to use the combined local expertise to the best effect. This means that with the right information sharing agreements it is possible to start to share essential information between different organisations systems. Examples of this so far include patient's blood results being accessible by a neighbouring acute /

specialist hospital, sharing of information for people with a learning disability to alert in advance of their next appointment and sharing of key patient information to support complex care teams to work together.

2.28 In October 2016, we launched EMIS[1] Viewer in all emergency, urgent and immediate care settings throughout Somerset. This enables urgent and emergency care teams to be able to see the patient's essential GP records, such as medications, which in turn will improve their ability to treat the person quickly and safely. To date, the system has been used more than 3500 times in Somerset, giving significant patient and service benefits. The plan for 2017/18 is to build on and extend this scheme to further improve direct care.

COMMUNITY SERVICES

Children and Young People's Mental Health

2.29 Somerset CCG has been leading on the delivery of Somerset's Transformation Plan for Children and Young People's Mental Health and Wellbeing (2015-2020) as part of a wider transformation of mental health services for children and young people (CYP) across the county. The Somerset plan was informed by the recommendations of the Future in Mind Report: promoting, protecting and improving our children and young people's mental health and wellbeing (DH, 2015), as well as local priorities.

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

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

2.31 Since April 2016, work has focused on setting up new services and recruiting to these services. The Single Point of Access for Child and Adolescent Mental Health Services (CAMHS) was launched in January 2017. A Community Eating Disorder Service for Children and Young People has also been launched which provides specialist support to children and young people with a primary eating disorder diagnosis. The

[1] EMIS is a type of GP practice patient information system which originates from the Egton Medical Information Systems company – EMIS Viewer enables other providers to link to the practice system

Enhanced Outreach Team, jointly funded with NHS England, is now operating 8am-8pm Monday to Friday with these timings to be extended to weekends. A new service to support young people in schools has also been procured and will commence in April 2017.

2.32 Other developments as part of the transformation programme include improvements in clinical pathways within tier 3 CAMHS, engagement work with young people champions, development of the CAMHS website and the recruitment of a CAMHS Participation Worker.

2.33 NHS England also released funds to the CCG to support a waiting time initiative to reduce the CAMHS waiting list. This enabled the waiting list for CAMHS treatment to reduce significantly throughout January and February 2017.

2.34 The transformation work has been supported by the South West Strategic Clinical Network. This has enabled joined up working with other local areas resulting in more consistency across the region and opportunities to benchmark Somerset's progress.

Special Educational Needs and Disabilities

2.35 Through the Children and Families Act 2014, CCGs have statutory responsibilities to provide services for children and young people with special educational needs and disabilities (SEND).

2.36 Throughout the past year, Somerset CCG has been working in partnership with the local authority to ensure this cohort is well supported and adequate provisions are in place.

2.37 The CCG has used an audit tool, produced by the Council for Disabled Children, to monitor progress around the SEND programme. Somerset CCG's Director of Quality and Safety is the senior champion for the programme and teams across the CCG are taking forward the SEND action plan. A re-audit is due to take place in June 2017 to assess progress.

2.38 The CCG have also recruited a consultant paediatrician as the Designated Medical Officer (DMO) for SEND. The DMO will work with both the CCG and the Local Authority to ensure a joined-up approach to implementing the Children and Families Act.

Transforming Care

2.39 The NHS England Transforming Care Programme is a national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Somerset CCG published its first draft of the Transforming Care Plan in February 2016, but decided that a further review of the Plan was required to strengthen the focus on

an all-age pathway incorporating both children's and adults' services. There will also be a strengthened governance set up with joint social care and health leadership, a greater focus on partnership working and a more prominent role for the Learning Disability Partnership Board working closely with Young People Champions.

2.40 The draft Somerset Transforming Care Plan will be ready by the end of March 2017 to allow for a period of consultation and comprises a number of workstreams focusing on building the all-age care pathway as well as co-production and engagement, workforce development and joint commissioning. These multi-agency workstreams will all provide individual action plans which will be monitored by the Transforming Care Steering Group and LD Transformation Board.

Dementia

2.41 Somerset CCG and Somerset County Council published its refreshed Joint Dementia Strategy in July 2016. The strategy is based on the Government's Challenge on Dementia 2020 document and the Well Pathway for Dementia (Preventing Well; Diagnosing Well; Living Well; Supporting Well; Dying Well). The Somerset strategy was also informed by a Public Health Health Needs Analysis and a stakeholder 'gap analysis' against the Well Pathway sections. The Strategy (underpinned by strategic and short term action plans), is available on the CCG website: http://www.somersetccg.nhs.uk/EasysiteWeb/getresource.axd?AssetID=5406&type=Full&servicetype=Attachment

Diagnosis Rates

2.42 Timely diagnosis of dementia helps people and their families to both actively keep well and to plan for their longer term care and support needs.

2.43 Somerset is working towards achieving the national ambition for a minimum of 66% of people (over 65) living with dementia to have a diagnosis. CCGs are monitored on this against national estimated rates. Out of the seven South West area CCGs, Somerset consistently ranks third in terms of this diagnosis marker. Only one of the seven CCGs (Bristol) is currently above the national ambition. Research is underway in Cornwall following the South West raising concern that the national estimates have been based on urban areas, and that this may affect how achievable this indicator is in local rural areas.

2.44 At the end of March 2016 Somerset's diagnosis rate was 61.5%, an increase since March 2015. However at the end of February 2017, the Somerset rate is 61.1% (with one set of Practice data missing). This indicates that diagnosis rates have remained static despite ongoing initiatives during the year, including: individual Practice case finding visits from a local GP Registrar and Dementia Scholar; a comparison of prescribing of dementia medicines and Practice diagnosis rates; and

regular communications with Practices, Acute Trusts and other partner agencies.

Annual Reviews

2.45 People living with dementia (and their carers), benefit from having annual reviews to ensure their needs are being met appropriately. The number of people diagnosed with dementia receiving these reviews; are monitored by NHS England through a remote data extraction facilitated through a quality framework (Quality Outcomes Framework) which only a minority of Practices in Somerset are signed up to. The majority of Somerset Practices are piloting a new framework for NHS England (Somerset Practice Quality Scheme). The CCG has commissioned an evaluation of the new framework from the Academic Health Science Network which suggests patients continue to receive good care.

Diabetes

2.46 In Somerset between 2,000 and 2,500 people are diagnosed with diabetes each year and currently 31,000 people in the county are living with diabetes. These numbers are projected to rise to 53,000 by 2030 if nothing further is done.

2.47 The Somerset Foot Pathway Group is a collaboration of diabetologists, vascular surgeons, podiatrists and commissioners who work together to reduce foot complications in Diabetes. By commissioning a specialist foot service the number of major amputations in Somerset has decreased. A national report published by Diabetes UK indicated this had avoided 19 amputations.

2.48 A project has been implemented to improve outcomes for people with hypoglycaemia, which has reduced 999 ambulance call outs for this condition by 300 a year, through the use of better self -management techniques.

2.49 Further work during the year has seen Somerset accepted as a pilot for the new national Digital Diabetes Prevention Programme in 2017. In addition, in collaboration with Dundee University, Somerset has won a prestigious Small Business Research Initiative (SBRI) Grant (GP of the Future category) to develop the prototype for My Diabetes My Way for England; an app designed to enable people to manage their diabetes and avoid complications.

Stroke

2.50 The stroke teams in Somerset have continued to work to improve the quality of their services over the past year and, in particular, to ensure that patients who are appropriate to have “clot-busting” thrombolysis treatment are receiving this treatment.

Early Supported Discharge Scheme

2.51 The Early Supported Discharge Scheme provides hospital level rehabilitation in people's own homes, enabling people to return home swiftly. It has been fully operational for a year, and following an evaluation was shown to be achieving excellent patient outcomes, high levels of patient and carer satisfaction and good value for money. With more people being treated in their own homes instead of a hospital setting, a temporary reduction in the number of community stroke beds from January 2017 has been trialled in order to continue this new model of care. This will be fully evaluated in the summer of 2017. The service has also trialled providing this same supportive discharge to a small number of people with and acquired brain injury with similar good results. This trial was extended to a second year, and will lead to recommendations for the future being made later in 2017.

Stroke Prevention

2.52 The CCG worked in partnership with industry to review people with atrial fibrillation to ensure they were receiving appropriate medication to help prevent a stroke. 500 people were identified for a medication review and recommended an appropriate anticoagulant as a result. It is anticipated that this has prevented up to 30 people from experiencing a stroke. During 2017 it is anticipated that this review will be fully implemented across the whole of Somerset.

Carers Services

2.53 From 2013 to 2021 it is estimated there will be a 46% increase in those aged 90 and over from 6,700 to 9,900. Many of their carers will have significant health issues themselves and will require a high level of support to continue with their caring role.

2.54 Many carers do not recognise themselves as carers, they see caring as an extension of their role as partners, parents, children relatives and friends of the person they look after. Often they are proud and independent, and some may even feel there is a stigma about asking for help. Many have no expectation or awareness of help being available or of their role being recognised.

2.55 Somerset County Council and the Somerset Clinical Commissioning Group have jointly commissioned a carers support service to support unpaid carers within their role and also former carers as the needs of carers span health and social care.

2.56 The aim of the carers support service will be to improve the quality of life for carers and former carers living in Somerset and to work in partnership with others to ensure equality of access with a coordinated approach to service delivery that is outcome focused

PRIMARY CARE

Co-Commissioning

2.57 Somerset CCG has been in a joint commissioning arrangement with NHS England since June 2015. The Primary Care Joint Committee has the responsibility to:

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

2.58 The Primary Care Joint Committee has made a number of important commissioning decisions and oversees a number of Primary Care work streams, which include:

- designing a local approach to the national Primary Medical Service contract review and approving the first year of the Primary Care Improvement Scheme
- overseeing the development of the Somerset Primary Care Plan, which includes CCG, STP and GP Forward View (GPFV) requirements for primary care over the next five years
- overseeing the progression and development of the Somerset Practice Quality Scheme (SPQS) to improve outcomes for people with long term conditions
- receiving updates and monitoring information on the position of Primary Care across the county, making contractual decisions regarding mergers and branch closures
- monitoring and overseeing the budgets relating to primary care spend in Somerset

2.59 During 2016/17 the CCG discussed the move towards full delegation of primary medical services and agreed to submit an application for consideration, subject to caveats regarding finance and human resources. As no response had been received by early March 2017, the CCG withdrew its application and instead agreed to work with NHS England to develop its joint commissioning function. It is expected that all CCGs will move to full delegation by March 2018.

2.60 The Primary Care Joint Committee will continue to meet in public on a quarterly basis to carry out its functions relating to the joint commissioning of primary care medical services.

Somerset Practice Quality Scheme (SPQS)

2.61 In 2016/17 Somerset CCG supported 57 member practices to improve the quality of care for patients through SPQS, the local alternative to the national Quality and Outcomes Framework (QOF). The CCG continues to work alongside the Academic Health Science Network and is awaiting the final evaluation. The interim findings suggest:

- Practitioners feel they are able to spend more time focusing on caring for patients
- the quality of care delivered has not been negatively impacted

2.62 During 2016/17 the SPQS scheme continued to fund Practices to work closely with other NHS organisations and to provide better joined up care for patients who have complex medical needs. It also continued to promote person-centred consultations in which the patient's needs and priorities guide the consultation.

2.63 During 2016/17 SPQS Practices continued their sustainability work and submitted encouraging sustainability plans to further ensure care for patients is not compromised. Alongside this Practices continued movement towards consistent measures of quality and safety across the health system. As part of SPQS Practices participated in the Institute of Health Improvement (IHI) quality improvement programme, an element of which will continue throughout 2017/18. Having a quality improvement approach across the health system will lead to both secondary care and primary care clinicians using consistent approaches to quality improvement through small tests of change using real time data to learn and improve. Several workshops were held throughout the year; with Practices attending and working collaboratively to identify areas of quality improvement.

2.64 Under the joint commissioning arrangements, NHS England and Somerset CCG have again agreed to extend the SPQS pilot for the 2017/18 contractual year. This means that Somerset will continue to be one of the few locations across the country where an alternative to the Quality Outcomes Framework (QOF) is being offered. Work has been undertaken around the 2016/17 SPQS scheme to ensure it fully aligns with the Sustainability and Transformation Plan developed for Somerset.

Improved Access to Primary Care

2.65 In October 2016 it was announced that Somerset CCG was identified as a transformation area for improved access to GP services. This meant that Somerset CCG is required to commission improved access services for the population of Somerset by 1 April 2017. The CCG believes primary care is best placed to meet the needs of the Somerset population, whilst delivering the requirements and outcomes.

2.66 Under improved access requirements, CCGs must:

- commission weekday provision of access to pre-bookable and same day appointments to general practice services in evenings (after 6:30pm) – to provide an additional 1.5 hours a day
- commission weekend provision of access to pre-bookable and same day appointments on both Saturdays and Sundays to meet local population needs
- commission a minimum additional 30 minutes consultation capacity per 1000 population, rising to 45 minutes per 1000 population per week in accordance with population need

2.67 The specification for improved access does not stipulate the service delivery model for improved access. This is to recognise that primary care federations are best placed to design a model that meet the needs of their population and deliver the intended outcomes and requirements. For the majority of Practices, the service model will build on the current delivery of extended hours by Practice but at scale and it is envisaged that most groups of Practices will be delivering improved access by the end of the first quarter 2017/18.

2.68 Actions already taken include extending access for patients so that all patients have access to GP services at evenings and weekends. In addition, training has been provided for receptionists to become 'health navigators' and a Practice Support Team for Practices facing severe challenges has been established. The CCG also forms part of this initiative and has secured funding for a pilot scheme to retain older GPs in the workforce. A future initiative will be to develop online healthcare resources to help patients find the answers they need to manage their own health or book a consultation if needed.

2.69 One of the main contributors to the instability of primary care services is the demand for same day care. There is an emerging theme that a key contributor to secure the future sustainability of the Somerset health system is to integrate same day services across seven days, joining up same day service provision within the health system to deliver better care for patients. Phase two of the improved access proposal is to deliver same day demand for services through hubs that are operational from 8am – 8pm, seven days a week. These hubs would be delivered by a collaboration of primary, community and urgent care providers, with patients being seen by the most appropriate person in a timely fashion.

2.70 In 2016, Somerset CCG committed to investing £5 million over five years into primary care as part of its commitment to developing Primary Care Services, which was derived from the Somerset approach to the nationally mandated PMS (Personal Medical Services) review. The funding for improved access forms part of this commitment to primary care.

Primary care workforce

2.71 Across the whole of the UK, primary care is experiencing severe workforce pressures. In Somerset this is certainly true and is characterised for example by significant reductions in the total number of GP and practice nurses over the last five years as more people have left the profession or left the county than have joined. At present, Somerset has approximately 1,400 whole time equivalent (wte) staff working directly within local GP Practices and these reflect the following:

- 740 administrators and non-clinical staff
- 330 wte GPs
- 200 wte nurses
- 150 other patient facing staff (including Health Care Assistants, Dispensers, phlebotomists, pharmacists, paramedics)

(Source of data: NHS Digital Primary Care Quarterly Workforce Census March 2016)

2.72 At present there are around 400 individual GPs in Somerset who account for approximately 330 whole time equivalent staff. This represents a loss of at least 30 GPs in the last 12 months alone and the CCG anticipates there will be a net reduction of GPs in Somerset for at least each of the next five years. The age profile of GPs and practice nurses in Somerset is higher than the national average. For example at present 23% of the GPs are already at or above the median national retirement age of 55 years and around 45% will have reached this age within five years from now. This picture is very similar for practice nurses. Workforce pressures within individual practices can vary considerably. There are Practices within which all the GPs have already reached retirement age and for some this is also coupled with long term GP vacancies, high GP to patient ratios, high vacancy factors for nurses and other staff disciplines.

2.73 A wider range of initiatives is being progressed in the county by Practices themselves, the Local Medical Committee (LMC), Somerset Primary Healthcare and the CCG which are intended to help address these pressures. These include:

- broadening the skill mix of staff deployed within primary care e.g. health coaches, clinical pharmacists and paramedics
- Practices providing some services together in future and sharing staff, resources and expertise
- Practices working more closely with local third and voluntary sector organisations to form a local primary care network
- Practices adopting different organisational forms through mergers or integration with local Trusts
- Practices offering new varied roles including portfolio working arrangements which would allow staff to work across a number of locations or clinical areas

- making changes to workflow within the Practice and changes to the way patients engage and use services provided by the Practice
- a variety of schemes which support GPs who have retired, or are soon to retire, to continue working in a clinical capacity within varied roles which align with their areas of interest

URGENT AND EMERGENCY CARE

2.74 Somerset Health and Social Care organisations in Somerset continue to work together to develop integrated urgent and emergency care services to ensure that patients with urgent care needs can access services that provide the right advice in the right place, first time with the provision of highly responsive urgent care services local to where people live wherever possible. This is overseen by the Somerset A&E Delivery Board for System Wide Urgent and Emergency Care (A&EDB).

A&E Delivery Board for System Wide Urgent and Emergency Care

2.75 The A&EDB was formed in September 2016 with the purpose of coordinating and overseeing the five national mandated improvement initiatives that have been developed which relate to A&E streaming at the front door, increasing the percentage of calls transferred to a clinical advisor, the Ambulance Response Programme, patient flow and improving discharge processes. The A&EDB is responsible for implementing the actions required and to also focus on the outcomes and processes necessary.

Urgent Care Programme Board

2.76 The Urgent Care Programme Board (UCPB) is a sub-group of the A&EDB and is responsible for all aspects of development of urgent care services, co-ordinating across the health and social care system to ensure that services are connected and the overall system works cohesively together.

Urgent and Emergency Care Services Clinical Assurance Committee

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

Escalation

2.78 There has been increased demand across the urgent care system within health and social care services during 2016/17 and this has remained a persistent challenge for all organisations. The Somerset system encountered sustained pressure throughout the year into the winter period. This pressure started to reduce towards the end of February 2017.

2.79 The Somerset Health and Social Care System Wide Escalation Framework has been developed to provide a consistent and co-ordinated approach, which will aid the management of pressures in the Somerset urgent and emergency care system and the implementation of appropriate actions to be applied during escalation. The Escalation Framework is in place to help providers of urgent and emergency care services make best use of all locally available resources as demand rises and/or capacity is limited, to sustain a safe, high quality service for patients/clients.

NHS111 Service

2.80 The Somerset NHS111 service has seen performance improvements over recent months. The number of patients that the service refers to the Emergency Department and to the Ambulance Service meets the national target. This represents a significant achievement and is a reflection of efforts that have been made to strengthen performance in these areas.

2.81 The service does get placed under significant pressure especially when this exceeds predicted activity and this therefore has an impact on achieving 95% of calls answered within 60 seconds. Somerset CCG and Somerset Doctors Urgent Care (SDUC), the provider of the service, are working in partnership to address these performance issues.

2.82 Continued joint working between Somerset CCG and SDUC will seek to find a collaborative plan that supports continued improvements within the service.

GP Out of Hours Service

2.83 The GP Out of Hours (OOH) service within Somerset continues to perform well across the majority of national performance measures, most notably for patients that need the most urgently required care of 60 minutes. This continues to be a consistently well performing area for telephone assessments, home visits and for patients that attend appointments.

2.84 The GP OOH service has seen some challenges regarding recruitment over recent months. This has created some challenges but is being addressed with a renewed recruitment drive.

2.85 Somerset CCG is working collaboratively with Somerset Doctors to improve performance for some patient groups. This work is focused on achieving improvement for patients that are clinically accessed to require a routine follow-up.

999

2.86 Within Somerset, South Western Ambulance Service Foundation Trust (SWASFT) has been participating in an Ambulance Response Programme (ARP) trial. The ARP trial has aimed to improve response times to critically ill patients, making sure that the best response is sent to

each patient's correct location first time with the appropriate degree of urgency. SWASFT is taking part in this trial alongside Yorkshire Ambulance Service and West Midlands Ambulance Service.

Delayed Transfers of Care

2.87 A Somerset System-Wide Delayed Transfer of Care Project was established from October 2016 to deliver a reduction in delayed transfers of care. A number of actions were agreed which incorporated better partnership working and included:

- Reablement Home Support Service supporting patients at home to avoid an admission
- Integrated Hospital Discharge Teams with NHS and Adult Social Care staff working together in the acute hospitals and a Discharge Pathway Manager from Somerset Partnership NHS Foundation Trust embedded within the team
- Multi-agency Practice Development Forums in the acute and community hospitals to identify discharge pathways for patients
- Additional Nursing Home Capacity put in place to aid discharge from the acute hospitals.

Winter Planning

2.88 The CCG has coordinated planning across health and social care to ensure that services are able to respond to increased demand on services during the winter period. The winter planning process in 2016/17 consisted of holding a winter planning workshop to develop an action plan that predicted demand for periods of anticipated heightened escalation, develop business continuity plans and ensure that communications to the public were in place during times of escalation.

2.89 Robust winter planning arrangements were implemented over the Christmas and New Year period which resulted in a reduction of pressure within the Somerset urgent care system. A winter debrief meeting was held to collect feedback and key learning points from all organisations in the Somerset urgent care system which will inform planning for winter 2017/18, and actions were identified from the meeting for individuals/organisations to take forward.

Severn Urgent and Emergency Care Network

2.90 Somerset is a member of the Severn Urgent and Emergency Care Network which replicates the trauma network and consists of eight CCGs, as follows: Bristol, North Somerset, South Gloucestershire, Bath and North East Somerset, Gloucestershire, Swindon, North Wiltshire and Somerset. The Network is responsible for taking forward and implementing the national vision for urgent and emergency care.

Quality, Innovation, Productivity and Prevention (QIPP) Schemes

2.91 Within 2016/17, two successful QIPP schemes were set up that impacted on urgent care services and these were:

- Urgent Connect
- GP 999 Car scheme

2.92 Urgent Connect was piloted for a five month period from November 2016 to provide a clinical telephone advice line for GPs to secondary care in a number of specialties with an aim to reduce GP emergency admissions. The pilot scheme has been well received by both primary and secondary care and has seen an increased number of hospital avoidances under acute medicine, acute surgery and acute gynaecology as well as financial savings for the system. The pilot has been extended into 2017/18 and further work is being undertaken to assess the longer term benefits in order to progress the scheme.

2.93 The GP 999 car scheme acts as a mobile treatment service where doctors and paramedics work together to manage patients with complex health needs at home where they otherwise would have been conveyed to an emergency department. The scheme that started in November 2016 operates two cars, one in the East and one in the West of the county on Saturday-Monday. It has seen some very positive results with around 88% of patients being treated in the community. Due to the success and financial savings, it has been agreed that the scheme will continue to run until at least April 2018.

ELECTIVE CARE

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

- Dermatology
- Ophthalmology
- Demand and Activity Management:
    - GP Variation
    - Patient Initiated Follow Up (PIFU)
    - Advice and Guidance
    - Consultant Connect

Dermatology

2.95 Dermatology services remain under pressure with significant support from the community enhanced service and the DERMIS triaging service. Somerset has continued to see growth in two week cancer and urgent referrals and the routine referral calls to the Referral Management Centre (RMC) have continued to see growth over the past 12 months.

2.96 The excellent service provided by the GPs with Special Interests (GPwSIs) within the community, continues to play a key role in the support of these extra pressures for routine patients. This enables secondary care to allocate its available capacity to urgent and cancer patient referrals.

2.97 Nationally there are still significant challenges due to recruitment shortages of dermatology consultants. These pressures have presented significant challenges for Taunton and Somerset NHS Foundation Trust (TST) and despite attempts to recruit in various ways over the past two years, TST has been unable to attract any new consultant dermatologists. In addition to there being a shortage of specialist medical staff in this area, those doctors who are trained often prefer to work in much larger centres with bigger teams where they can support academic and clinical research work as well as develop further specialist clinical expertise. Due to these pressures, TST notified the CCG that they had no alternative but to close the service to all new referrals in December 2016. As a result, the CCG established a working group involving TST and all surrounding providers.

2.98 The impact of the capacity shortfall at TST has been significantly reduced due to the collaborative efforts of neighbouring trusts being facilitated by Somerset CCG. All urgent two week wait patients have been successfully managed by the Referral Management (RMC) and allocated to the closest available hospital over this period within the timescales set out in the NHS constitutional standards. Somerset CCG has been monitoring demand and capacity on a daily basis and in response to periods where demand is greater than available capacity the CCG has worked with neighbouring providers to unlock capacity to ensure that patients are seen in a safe and timely way. As an interim arrangement for new referrals, Somerset CCG has worked in partnership with all neighbouring hospitals to set up alternative services for urgent referrals including possible cancer patients. The short-term and ongoing support that Somerset CCG has received from University Hospitals Bristol, Royal Devon and Exeter NHS Foundation Trust, Royal United Hospitals Bath and Yeovil District Hospital has been critical in ensuring that patients needing an urgent appointment are seen quickly.

2.99 For the longer term Somerset CCG is doing everything it can to maintain dermatology services within the county for Somerset patients. This includes working to identify a new service provider to establish and support a sustainable service for patients within Somerset, delivering care from TST. Plans to deliver this are progressing well and at a recent CCG Clinical Operations Group meeting the CCG confirmed that the CCG wish to accept the proposal and proceed with the development of a substantive service, working collaboratively with University Hospitals Bristol (UHB) as lead provider and other providers.

2.100 In line with the proposal and to support the transition during 2017/2018 the CCG has agreed that the phototherapy (PUVA) service and the follow up activity for patients will remain at TST.

2.101 In conjunction with the lead provider Somerset CCG is looking at how technology can support a change in the way that patients are managed. Tele-dermatology is a technology which, at present, is being explored as part of the two week wait, urgent referral and routine dermatology service. Opportunities are being explored, with the lead provider and NHS England, about how this technology can enhance care for patients. As part of the ETTF (Estates and Technology Transformation Fund) submission the CCG has recently been successful in securing funding for the development and roll out of a demand management tool for dermatology.

2.102 Somerset CCG recognises that for some patients travelling to providers out of county is difficult and has made efforts to reduce the travel time where possible by managing the process through the Referral Management Centre. In addition a number of more routine referrals can be seen locally by the team of GPs with a specialist interest in dermatology working in Somerset. As part of forward planning Somerset CCG wants to ensure that the Somerset Dermatology service will be an integrated service encompassing all aspects of care for patients in the most appropriate setting. This will be supported by a strong focus on prevention and the service will also support people to self-manage long term skin problems by equipping them with the information and education they require.

Ophthalmology

2.103 Somerset CCG established an Ophthalmology workstream in September 2016 and work continues on the following key areas:

E Referral Advice and Guidance (A&G)

- the Group agreed that e-Referral Advice and Guidance for ophthalmology should be progressed. This will be taken forward through the Referral Management Centre, as part of the work for expanding to new specialties.

Acute Community Eye Care Service for Somerset (ACES)

- exploratory work is underway on extending the service to enable access over a 48 hour period rather than the current 24 hours, to further help reduce the number of emergency eye referrals to A&E. Potentially more patients could be seen within ACEs during the week, rather than presenting at A&E during the weekend if the criteria to be seen is extended from 24 to 48 hours
- YDH conducted an audit of patients that could have been seen by ACEs that presented to their ED over the weekend
- the audit showed that approximately 380 patients per year could be seen over the weekend if ACES was available

- It was estimated that TST patient numbers would increase the figure to approximately 1,100, without the need for a further audit. TST agreed with this figure
- further work will be undertaken to extend the service in 2017/18

Skill Mix on Pathways

- these could be broken into component parts and tasks such as taking measurements could be done by technicians freeing up consultant time for more complex aspects

- TST is developing a Business Case to change the current model of service delivery, for nurses and technicians to see more routine cases in clinics. This model would require investment and training for both nurses and technicians. The training for nurses would be twelve months and for technicians six months. This model will provide the opportunity for consultants to see more complex cases and support the team to meet the demand on their service

Demand and Activity Management

2.104 The team at the Referral Management Centre (RMC) provides support to the GP Referral Variation project through the provision of data packs on GP Referral Variation and providing resource to support Practices with audit and training.

2.105 The RMC is directly supporting the work around Referral to Treatment Times (RTT) in two key ways to facilitate the waiting list transfers from TST where clinically appropriate:

- patients are able to access shorter wait times in the independent sector
- having detailed choice discussions to maximise use of the independent sector

2.106 The RMC continues to provide support to address local capacity issues within specialities and providers including the capacity issues in the Dermatology service.

2.107 SCW CSU undertook an evaluation of potential benefits of providing clinical triage support in the RMC and benchmarking services and outcomes against other centres in the south west.

2.108 This work programme includes expanding the availability of Advice and Guidance (A&G) to other specialities, including ENT, Cardiology and Urology. It also includes increasing the use of the current e-Referral A&G services already commissioned in Somerset. The local Booking Management Service (BMS) are implementing ‘Gateway’ checks to understand if patients are ready, willing and able to attend their appointment in the next 18 weeks. In addition, a field force team will be

working with GP Practices to help reduce referral variation, including supporting best practice, improved use of clinical system aids in EMIS and better clinical education and engagement for GPs. The Planned Elective Care Control team will also use this work programme as an opportunity to share and learn across similar teams within the South West.

Reducing GP Referral Variation

2.109 To reduce referral activity and variation within GP Practices in Somerset the CCGs Elective Care Team and SCW CSU Referral Management Team visited 18 of the highest referring GP Practices to identify and understand why their referral activity was high. These GP Practices were provided with a data pack highlighting specialties where their referrals were above the Somerset average and following each of those meetings, an action plan has been agreed. Emerging themes and feedback received following these visits included:

- Advice and Guidance:
    - update for GPs on existing A&G service that are available
    - increase in current service provision within A&G
    - more A&G services to be made available to clinicians including Cardiology, ENT and Urology
    - Consultant and Urgent Connect telecoms pilot
- Training and Engagement:
    - more sessions to be delivered to Primary Care, specifically Cardiology, Child and Adolescence, ENT, Geriatric Medicine, Respiratory
    - need for peer-to-peer cross Practice reviews of referrals
    - secondary care feedback around avoidable referrals
- Improved System for Referrals Pathway:
    - CCG exploring options to use the current functionalities in EMIS in order to replace the Pathway Navigator App

2.110 Activity levels of 17 of those GP Practices have shown an overall reduction of 15% in weekly referrals.

Patient Initiated Follow Ups

2.111 Patient Initiated Follow Ups (PIFUs) were introduced by providers from June 2016. These are not dissimilar to open appointments in that the patient has a period of time in which they can contact the consultant without a referral via the GP. Depending on the conditions, patients have between 3 and 12 months before a PIFU expires. At the point a PIFU

expires the provider is able to remove the patient from the pending list and confirm a saved follow up appointment.

Somerset Elective Care Delivery Board

2.112 The Somerset Elective Care Delivery Board has been established to oversee all Elective Care services under the acute workstream of the Sustainable Transformation Plan (STP).

2.113 The Elective Care Delivery Board is chaired by the Managing Director of Somerset CCG and comprises representatives from:

- Somerset CCG
- Taunton and Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Care UK
- NHS England
- NHS Improvement
- Cancer Alliance
- Nuffield Health

2.114 The primary objectives of the Somerset Elective Care Delivery Board are to ensure focus is maintained within the following areas:

- recovery of Somerset's RTT and Diagnostic performance
- patient centred and integrated services without obvious organisational boundaries
- review of the RMC arrangements, to ensure service delivery is maximised to support referral management
- high levels of safety and clinical effectiveness
- development of QIPP and RightCare opportunities
- recovery of the orthopaedics RTT position following the MSK (musculoskeletal) clock recording amendment
- theatre efficiencies
- identification of elective unsustainable services and development of plans to manage risks of service failure
- cancer performance, including the Sustainability and Transformation Fund (STF) 62 day cancer referrals and developing action plans where performance deviates from plan

2.115 The key areas of work that will be reported to the Somerset Elective Care Delivery Board are:

- Demand Management
- RightCare
- Development of the Elective Care Dashboard
- System Performance
- Policies of Limited Clinical Value (POLCV)
- Role of the RMC

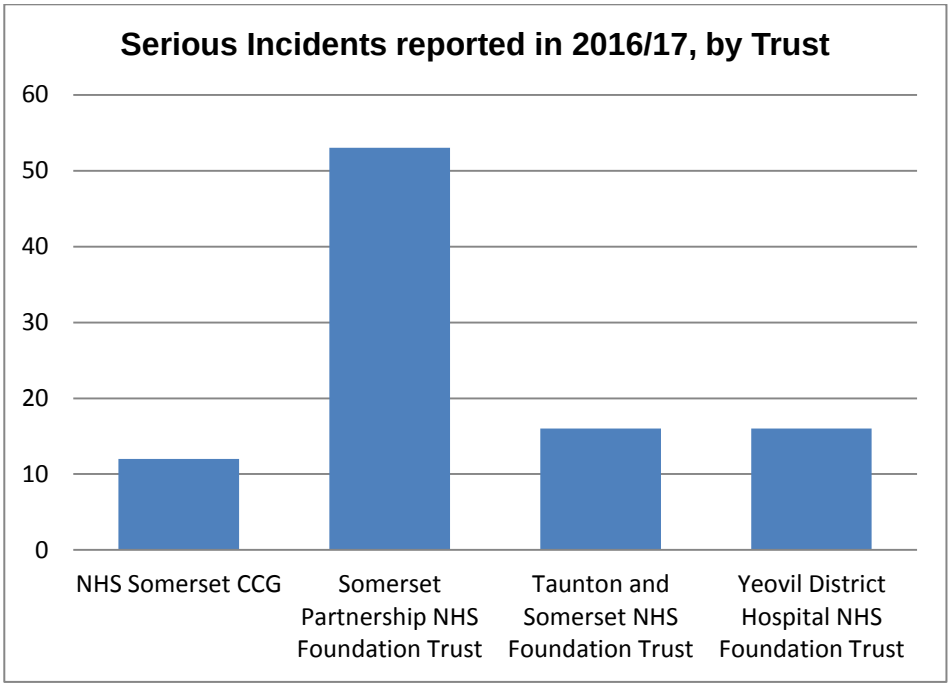
IMPROVING QUALITY AND THE PATIENT EXPERIENCE

Patient Safety Serious Incidents

2.116 Incidents which result in significant harm to patients receiving care funded by the NHS are required to be reported to NHS England. The CCG is responsible for ensuring a thorough investigation is carried out by the provider. The CCG independently reviews such investigations and ensures that lessons learned are embedded to improve the safety of care. Included in these reviews are incidents which are categorised as "Never Events". These are patient safety incidents which are serious and largely preventable and which should not occur if the available preventative measures have been implemented.

2.117 During the period 1 April 2016 to 31 March 2017, a total of 97 serious incidents were reported by Trusts for which Somerset CCG is the main commissioner:

Chart 1:



2.118 Included in these 97 serious incidents, were 8 never events. Details are in Table 1 below.

Table 1:

Trust	Never Event Incident Type
Taunton and Somerset NHS Foundation Trust	Surgical/invasive procedure x 6
Yeovil District Hospital NHS Foundation Trust	Surgical/invasive procedure x 2

2.119 In addition to these 97 serious incidents, Somerset CCG was notified of 23 serious incidents for Trusts where Somerset CCG is not the lead commissioner, but which involved Somerset patients, as detailed in Table 2 below.

Table 2:

Trust	Never Event Incident Type
Avon and Wiltshire Mental Health Partnership	Pending review x 1 Disruptive/aggressive/violent behaviour x 1
Royal Devon and Exeter Hospital	Surgical/invasive procedure x 1 (Never Event)
Weston Area Health	Environmental incident x 2 HCAI/Infection control incident x 1 Pressure ulcer x 4 Sub-optimal care x 1 Slip/trip/fall x 1
South Western Ambulance Service NHS Foundation Trust	Treatment delay x 5 Sub-optimal care x 1
United Bristol Hospitals	Medication incident x 1 Pressure ulcer x 2 Sub-optimal care x 1
Primary care	Medication incident x 1

Lessons learned from serious investigations

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

Somerset Partnership NHS Foundation Trust - Mental Health Services (Adult)

- Crisis team/home treatment team to explore the development of a specific role in relation to supporting homeless/ people without a fixed address
- Trust to review Talking Therapies website to ensure that it is appropriate for young adults
- letter to be sent to recently discharged patients to include information on who to contact if things change, to ensure robust continuity of care and communication
- review how to manage the potential ligature points between doors and door frames on secure in-patient wards
- all nurses on secure in-patient wards to personally carry ligature cutters

Somerset Partnership NHS Foundation Trust - Child and Adolescent Mental Health Services (CAMHS)

- review services and interventions offered to young survivors of sexual abuse
- develop a comprehensive discharge summary/report which should include detailed information about risk related issues
- improve communication between mental health service and GPs, particularly where looked after children are moved from GP to GP and the chain of information broken
- handovers from CAMHS to adult services should have a full formulation of risk that identifies significant issues such as past abuse and being a 'looked after child', and how these risks will be managed

Taunton and Somerset NHS Foundation Trust

- dental extractions:
    - review treatment pathway to ensure efficient investigation and assessment of head and neck patients with appropriate dedicated clinical support
    - agree standard for dental nomenclature (two methods would minimise errors)
    - the operating surgeon should check consent by referring to the original clinical notes made by the individual requesting the extractions

Yeovil District Hospital NHS Foundation Trust

- implement an emergency department checklist to ensure safe and timely management of patients, irrespective of referral or presentation mechanism
- review emergency department escalation triggers to ensure safe and timely management of all patients in the department
- review arrangements for direct admissions to Emergency Admissions Unit to ensure safe handover and management of care
- redesign the existing in-patient chart, so the venous thromboembolism (VTE) prophylaxis section obviously includes anticoagulants and Low Molecular Weight Heparin (LMWHs) will be on a page that is facing regular medication, so staff will be better aware that a patient may already be prescribed anticoagulants
- review medication check process at discharge

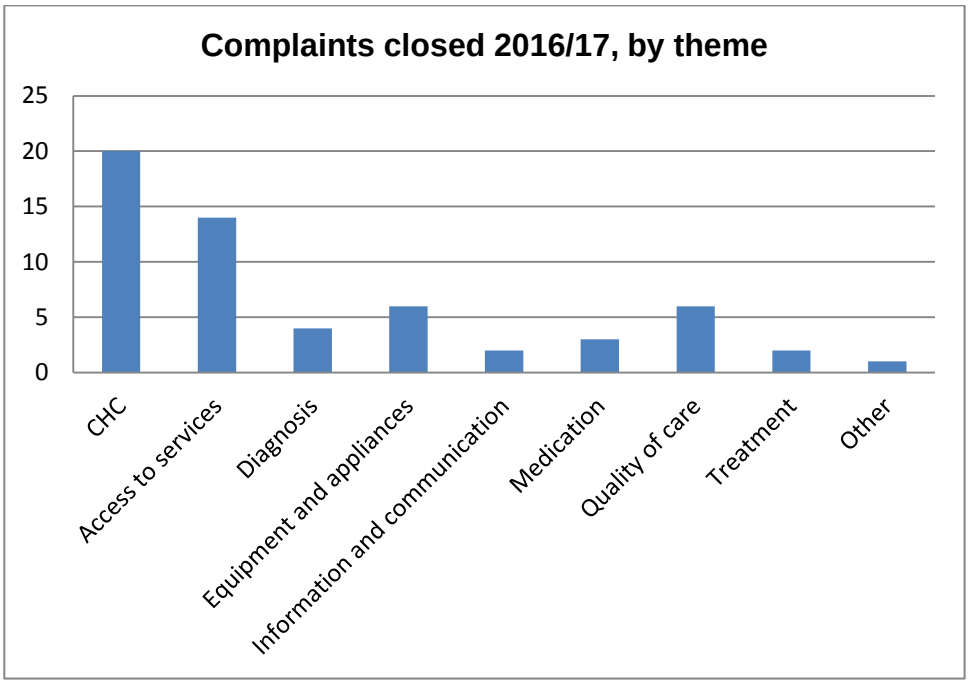
Complaints, Patients Concerns and Feedback

2.121 Somerset CCG values complaints and other forms of feedback, which are vital to continually improve the quality and safety of local health services and how services interact and are coordinated across the patient pathway. There are a range of mechanisms through which the CCG

captures information about the quality of patients' experiences of healthcare and wider community intelligence. All feedback messages are captured, collated, analysed and categorised.

Complaints

2.122 During 2016/17 Somerset CCG closed a total of 58 complaints. The main themes arising from complaints were:



Patient Advice and Liaison (PALS) Service

2.123 The Patient Advice and Liaison Service (PALS) provide a point of contact for people and someone to listen to them. The service is valuable in providing patients with a clearer understanding of how the NHS works. The PALS service also offers an impartial perspective and gives people the opportunity to feed back their concerns.

2.124 Time spent answering people's concerns or explaining changes to services or choices is rarely wasted and can provide reassurance for people at a time when they are worried about healthcare issues. Paying attention to what is trending is essential intelligence for the organisation and patients are telling us they want to be listened to and to work in partnership with their healthcare providers.

2.125 The service received 901 enquires in 2016/2017, an increase of 23% from the previous year total of 732.

2.126 The most frequent issues raised related to:

- difficulties getting to hospital appointments
- waiting times for outpatient appointments and surgery

- queries about medicines
- queries about continuing health care funding
- access to services

Healthcare Professional Feedback

2.127 Feedback from GP Practices relating to the safety of health and social care provision in Somerset, via the Health Professional Feedback e-form has been a valuable source of intelligence, with all GP commissioning localities engaged in using the mechanism to inform the patient safety team of concerns, compliments and improvement ideas. The feedback numbers received in 2016/17 was in line with the previous year.

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

2.129 Health Professional Feedback was created to provide a mechanism for primary care to feedback about Patient Safety concerns in the health and social care environment. However, we are seeing rising feedback relating to GP capacity and frustration around contract issues brought about by the NHS Forward Plan.

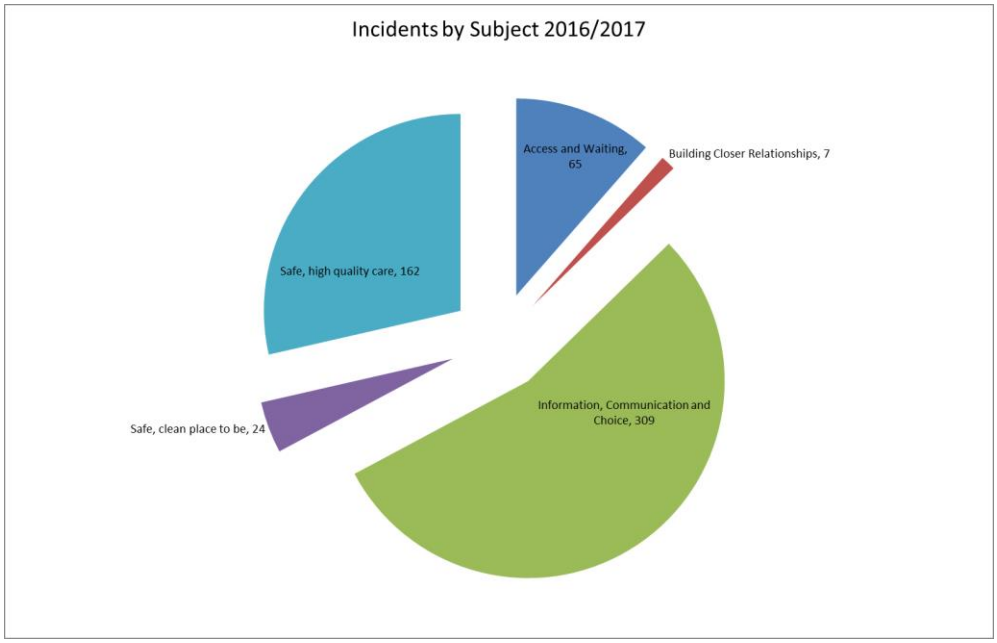
2.130 This year the Patient Safety Team has liaised closely with the Patient Safety Leads in Yeovil District Hospital, Taunton & Somerset NHS Foundation Trust and Somerset Partnership NHS Foundation Trust, providing one to one Datix training and secure access to the individual feedback messages received by GPs relating to their individual services. This has greatly improved the communication between the reporters of the feedback and the providers and has helped to manage the work load for the CCG Patient Safety Team in relation to investigating some of the issues raised.

2.131 We make every effort to feedback directly to the reporter and also to primary care on a quarterly basis on key issues that have been identified through the weekly GP Bulletin, Somerset CCG Newsletter, Safety Net and the Medications Management Newsletter.

2.132 In response to comment from primary care that feedback is still not sufficient, we are looking to have a ‘You Said, We Did’ section on the CCG Feedback page on the GP IT Desktop which will provide additional opportunity for primary care staff to see what the CCG is doing in response to the feedback it receives.

2.133 The chart below shows the breakdown of the themes collected for both medication and health professional feedback.

Chart 2: Feedback themes for April 2016 - March 2017



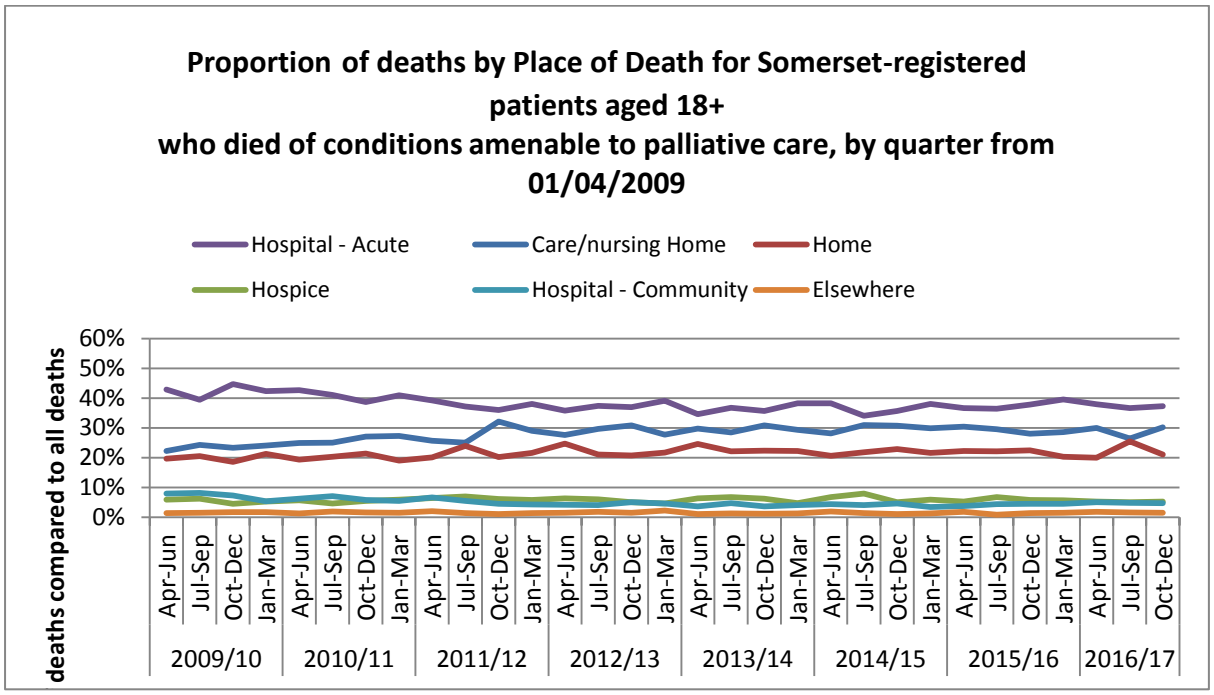
End of Life Care

Background

2.134 Around 5,500 people die each year in Somerset, and with the changing demographics this is projected to rise by 17% between 2012 and 2035. The percentage of deaths occurring in the group of people aged 85 years or more is expected to rise from 32% in 2003 to 44% in 2030. Approximately three quarters of deaths are expected, so there is potential to improve the experience of care in the last year and months of life.

2.135 Figure1 shows the data on place of death in Somerset from April-June 2009 to Oct-Dec 2016. Although there are small variations quarter to quarter, overall the pattern has changed little in the past few years, with home deaths remaining at about 20%, deaths in Care Homes at about 30%, and deaths in acute hospitals at about 37%. Place of death is not the only marker of good end of life care, or even a very good marker, but it is of concern that despite the considerable effort being made to move the care of those who are terminally ill away from acute hospitals, these figures are not improving.

Figure 1:



2.136 The National End of Life Care Intelligence Network produces rolling annual data for deaths in usual place of residence, (deaths in own home and care homes). The most recent data available is for 2015/16 Q3-2016/17 Q2. Data for Somerset, the South West, and England, is shown in figure 2.

2.137 It is of concern that there has been a small but steady reduction in the percentage of people dying in Somerset in their own home or a Care Home. One possible reason for this may be the well documented shortage of domiciliary care packages.

Figure 2:

	Somerset	South West	England
2015/16 Q3-2016/17 Q2	49.8%	51.7%	45.7%
2015/16 Q2-2016/17 Q1	49.5%	51.6%	45.7%
2015/16 Q1-2015/16 Q4	50.3%	51.7%	45.8%
2014/15 Q4-2015/16 Q3	50.8%	51.9%	46.0%
2014/15 Q3-2015/16 Q2	51.7%	52.0%	45.9%
2014/15 Q2-2015/16 Q1	51.9%	51.8%	45.7%
2014/15 Q1-2014/15 Q4	51.1%	51.5%	45.6%
2013/14 Q4-2014/15 Q3	51.5%	51.4%	45.1%
2013/14 Q3-2014/15 Q2	50.9%	51.2%	45.1%

Achievements in 2016/17

Learning from End of Life Care complaints

2.138 Last year's annual report featured the story of Brian. Brian had kindly shared his story with the CCG Governing Body to demonstrate how end of life care affects patients and their families so that learning could improve the quality of services.

2.139 In response to this and a number of other complaints/concerns that had been brought to the attention of the CCG, the CCG hosted an End of Life Learning Event in October 2016. Representatives from primary care, secondary care, the community nursing team, the emergency services and St Margaret's Hospice attended. At the event, the attendees agreed a list of improvement actions that included:

- to improve communication with families and ensure they know what will happen in the time leading up to death and make sure a range of different information resources is provided
- expand the work to develop compassionate communities circles of support, across a wider area so that families have improved access to support
- improve arrangements for timely access to anticipatory medication (Just In Case boxes and syringe drivers)
- improve arrangements for access to and administration of pain relief, especially in the out of hours period or over bank holidays

2.140 These actions are being taken forward in the coming year by the End of Life Clinical Programme Group as part of their work programme. This Group was set up in Somerset a few years ago to drive improvement in end of life care and has been working with all service providers.

2.141 Early progress has already been made by the Group around improving access to timely pain relief. A pilot project is currently underway where a small number of family members have been trained by clinical staff to administer injections for urgent symptom control, for end of life patients. This is a new development, but given the rurality of Somerset and the delays that may occur before a trained health care professional can attend to administer an injection for urgent symptom control, particularly in the out of hours period, this could have significant advantages. The early feedback from this pilot has been very positive.

Developing the Somerset End of Life Care (EOL) Services

2.142 The Somerset CCG EOL Care Strategy has been reviewed, and a countywide approach taken. The strategy is supported by all health providers in Somerset. A work plan for the End Of Life Programme Group has been developed from the strategy.

2.143 Using funds provided by NHS England SW, the Advance Care Planning, (ACP), education project has continued both in Taunton and Somerset NHS Foundation Trust and in the community, based around small locality groups. Examples of innovative work have been the use of ACP by health coaches in general practices; by the respiratory team in Taunton and Somerset NHS Foundation Trust; by the Memory Strategy group, and by the Integrated Rehabilitation Teams.

2.144 The development of compassionate communities in Somerset has continued. This is a movement to help family, friends and neighbours support people dying at home.

2.145 Work has started in Frome which includes identification of people likely to die in the next year; offering community led advance care planning and network development skills; provision of training in manual handling and administering sub-cutaneous injections by lay carers, and the development of supportive networks around the person who needs help.

2.146 The Just in Case policy has been reviewed. This encourages the provision of injectable medication to be kept in a patient's home before it is needed, 'just in case', so this is available particularly during the out of hours period. Some of the symptom control guidance has been updated in line with current best practice, and a clear framework put in place to enable non-professional carers to administer sub-cutaneous injections for urgent symptom control.

2.147 A Verification of Expected Death of Adult Patients by Registered Nurses Policy has been developed for Somerset Partnership NHS Foundation Trust. This should reduce the burden on GPs verifying death, particularly in the out of hours period. A similar policy will be offered to Care Homes with Nursing, using the same framework.

2.148 During this year it has become apparent that there are significant challenges to be overcome in our current Electronic Palliative Care Co-ordination System (EPaCCS). The Clinical Programme Group has been working with the CCG IM&T & SIDER teams to address these and find both short term and long term solutions. The current system has been improved, but is based on old technology, and a more modern system is being considered, depending on the availability of resources from a bid to the NHS Estates and Technology fund.

2.149 The Clinical Programme Group has been exploring the use of Personal Health Budgets for Fast Track patients as a way to expedite the provision of care to people towards the end of their lives. It is hoped that this will facilitate the speedier discharge of patients from acute trusts and hospices waiting for packages of care before they can return home.

2.150 The Clinical Programme Group is working with the SW Academic Health Science Network, the Commissioning Support Unit, the national End of Life Care Intelligence Network, and our local Public Health service, to

explore ways of using all available information to improve the quality of our end of life care in Somerset.

Priorities for 2017/18

2.151 To continue to work on a replacement EPaCCS system, to ensure that all providers including the out of hours and ambulance services are aware of patient's end of life wishes.

2.152 To develop a programme dashboard, including number of days spent in acute hospital in the last year of life, and to continue to explore the use if data for quality improvement.

2.153 Compassionate Communities – to continue to develop the CCG as a Compassionate Organisation, and continue to work towards Somerset becoming a Compassionate County.

2.154 To further develop appropriate ways to hear patient stories, and implement the learning from them.

2.155 The 'Proactive Palliative Care' project will run throughout 2017. This is a general practice based training programme using simple audit tools to help Practice teams reflect on the end of life care that they provide and to make improvements.

2.156 To develop the use of Personal Health Budgets in end of life care.

2.157 To seek agreement across the Somerset health community about the development of a single countywide 'Treatment Escalation Plan' (TEP), taking into account the ReSPECT for and process that the Resuscitation Council has recently published.

2.158 Sharing the journey – right person right place right time: to complete this project funded by Health Education South West and seek to improve Advance Care Planning for patients approaching the end of their life.

Sign Up to Safety

2.159 Somerset CCG, working with our health service providers, has continued to work on a wide range of safety and quality improvement initiatives focused around known key safety risk areas, in particular:

- pressure ulcers; deep skin damage caused by prolonged pressure
- harms arising from falls
- the need to diagnose and treat sepsis quickly
- distress and harm caused by poor communication as part of planning and arranging care
- adverse effects from medications

- damage to kidneys through de-hydration – often associated with being unwell and not taking in enough fluids, which can be compounded by certain medicines
- control of infectious diseases such as MRSA and clostridium difficile

2.160 In June 2016 Somerset CCG won a prize in the national Sign Up to Safety competition for the development and publication of information aimed at raising public awareness about these risks. A copy of this information titled 'How to make sure your healthcare is safe' can be found on the Somerset CCG website at http://www.somersetccg.nhs.uk/publications/patient-information/

2.161 Health service providers in Somerset have made improvements in a wide range of areas associated with these risks, such as:

- adoption of the National Early Warning Score (NEWS) framework across Somerset to assess patients at risk from rapid deterioration in their health, including from sepsis
- reducing the time taken to administer intra-venous antibiotics following recognition of high risk of sepsis
- review of medication risks through individual patient medication review systems
- increased use of electronic transfer of information and ensuring people are given a copy of their discharge information when leaving hospital
- continuing to review and share learning from incidents so people can be better supported to reduce the risk of pressure damage. For example, understanding why people who at risk are sometimes resistant to changing their resting position sufficient to alleviate pressure risk.
- identifying and supporting people who are at increased risk of falls and harm from falls due to their greater level of frailty
- providing advice to patients who are taking medicines which increase the risk of kidney injury when they have bouts of illness, known as the 'sick day rules'

2.162 A range of forums have been established, or further developed during the year to support continuous improvement in quality and safety. These include:

- the Somerset Quality Improvement Network
- the Somerset sepsis working group
- the Somerset Pressure Ulcer Collaborative

- training events for primary care and home care services on clinical risk management and incident investigations

Continuing Healthcare Assessment Teams

2.163 NHS Somerset Clinical Commissioning Group took the decision in August 2016 to in-house the Continuing Healthcare and Funded Nursing Care Assessment Teams whose service was commissioned through Somerset Partnership NHS Foundation Health Trust. The decision was taken to in-house the service primarily to improve the quality of assessment and patient and family experience through directly influencing the operational process and better supporting the staff to deliver the service. The Assessment Teams were successfully transferred to the Clinical Commissioning Group on 1 March 2017 and are being prepared to deliver their roles through a dedicated induction and development programme. The Clinical Commissioning Group is also recruiting additional clinical staff to support these teams as it is recognised that the current level of staffing is not yet sufficient to meet the demands on the service. The benefits to in-housing this team and building capacity are set out below:

- the service to operate as a fully functioning team able support quality of assessment and decision making
- patients will have access to the right professional including mental health, learning disability, children's nurse and social worker as part of a multi-professional assessment team reducing barriers to the process and rigour to decision making
- patients who are eligible for continuing healthcare assessment will be assessed
- quality line management and clinical supervision to support revalidation of professional registration
- enhanced support to hospital discharge teams from nurse advisors
- retention of continuing healthcare staff through supporting capacity and professional development and expert leadership.
- appropriate administrative support for nurse assessors in their roles will free up clinical time. Dedicated administrative staff skilled in their roles will also support quality data capture across the assessment teams to strengthen data reporting and to support clinicians in prioritising their workloads.
- aligning workforces to provide accurate capacity and demand modelling, improving productivity and efficiency function.
- invest to save with timely assessments and reviews ensuring that only eligible patients are accessing continuing healthcare and funded nursing care funding.
- robust processes which demonstrate consistency and quality decision making, reducing appeals and complaints.
- increase in capacity to identify and trigger safeguarding concerns and support to care homes

Previously Un-assessed Care

2.164 On 15 March 2012 the former Chief Executive of NHS England, Sir David Nicholson, wrote to all Primary Care Trusts to say that the Department of Health had requested that Previously Un-assessed Periods of Care dating back to 1 April 2004 should be closed. Work on this has been on-going since 2012 and NHS Somerset CCG received 680 claims to process. On 10 March 2017 the Clinical Commissioning Group made a final decision on the last case to be closed and has now completed all cases within the time frame stipulated by NHS England.

Care Home Support Team

2.165 In 2015 Somerset Clinical Commissioning Group commissioned the Care Home Support Team, to support nursing homes to improve quality and reduce avoidable hospital admissions.

2.166 The team comprises professionals including a Registered Nurse, Infection Control Nurse Specialist, Social Worker, Medicines Manager and a Safeguarding Lead Nurse.

2.167 The team can support nursing homes with Infection Prevention and Control, clinical matters such as pressure ulcer prevention, training and revalidation, safeguarding, mental capacity, and Deprivation of Liberty Safeguards (DOLS), optimising medicines and antimicrobial stewardship.

2.168 The team can provide this support by a visit, over the telephone or by email.

2.169 During visits, the team can provide 1:1 support to managers, awareness-raising workshops for entire staff teams, and/or review documentation.

2.170 The team also run quarterly Learning Engagement Meetings with the acute trusts and nursing homes, where issues with hospital admissions and discharges are discussed and resolved, and guest speakers provide practice updates.

2.171 The team produce a quarterly newsletter for the nursing homes.

2.172 The Care Home Support Team submitted a return to NHS England in September 2016 to evaluate the work that the team had undertaken over the past 12 months. As part of the evaluation care homes were asked about training, staff skills and whether training supported them to improve care over the past year. 86% of respondents felt that access to training had improved, 78% of respondents agree that the skills of staff had increased, and 74% of staff felt that training had helped to improve care. The evaluation also found that the team was able to use a range of learning methods to upskill staff tailored to the specific needs of individual providers and progress was supported by homes accessing a

multidisciplinary team. Over the year, the team supported 59 nursing homes and eight residential homes.

2.173 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

Safeguarding Adults

2.174 Somerset CCG has continued to contribute to the work of the Somerset Safeguarding Adults Board (SSAB). This is a statutory body established by the Care Act (2014) The main objective of the SSAB is to protect all adults in its area who have needs for care and support and who are experiencing or at risk of abuse of neglect against which they are unable to protect themselves because of their needs.

2.175 The CCG has contributed to the work of the SSAB and provides representation at a senior level for both the board and the four subgroups that undertake work programmes to improve outcomes for people who may need protection from harm or abuse.

2.176 One of the functions of the SSAB is to commission Safeguarding Adults Reviews (SAR) for any cases that meet the criteria. A Safeguarding Adults Board must arrange a SAR when an adult in its area dies of, or experiences serious abuse or neglect, and there is concern that agencies could have worked more effectively to protect the adult.

2.177 In 2016/7, the Somerset Safeguarding Adults Board published the outcome of three reviews of serious cases on their website https://ssab.safeguardingsomerset.org.uk/about-us/publications/ . Somerset CCG contributed to the reviews that were undertaken, including the development and implementation of action plans to address any identified learning or improvement needs. The CCG also contributed to the development of practice briefing notes that summarised the cases and were circulated to health and social care practitioners in the area. Examples of the areas of learning identified include staff being able to recognise and share effectively the signs of abuse or neglect, and the importance of early intervention when concerns arise. The reviews also highlighted the need for detailed specialist assessments to be implemented in a timely way. Another theme across all three reviews was the need to ensure compliance with the Mental Capacity Act (2005). This includes the requirement for capacity assessments and best interest decisions to be effectively completed and recorded for those people where there may be doubt about their ability to make decisions relating to their own welfare and safety.

2.178 Somerset CCG has taken the lead on and supported a number of quality improvement and whole service concerns. When there are concerns about care homes in the Somerset CCG area, then one of two

frameworks are applied, a whole service safeguarding process or a quality improvement process. Homes may move between frameworks depending on the level of risk.

2.179 This includes contribution to the whole service concern process in relation to Mendip House; owned and operated by the National Autistic Society. Mendip house closed in November 2016 following allegations of serious neglect and mistreatment of residents. Mendip House was located on the Somerset Court site in Somerset where a further six homes remain. Multiple organisations commissioned care across the services. Somerset CCG supported the whole service concern process that was applied to Mendip House and the other homes on the site whilst the local authority undertook a section 42 enquiry under the Care Act (2014) and CQC inspected the sites. The CCG also provided representation at a senior level on a strategic board that co-ordinated and took oversight of the process and liaised with all other health commissioners who funded placements at the service. This whole service concern process concluded in January 2017 and regular monitoring of the remaining services continues.

2.180 Somerset CCG has led a quality improvement process with Cygnet hospital, which is a private hospital providing care and treatment to adults with mental health needs including those detained under the Mental Health Act. The hospital was inspected by CQC in August 2016 and found to be inadequate. The quality improvement process involved liaison with ten other health commissioners who over the period of time funded placements at the service.

Safeguarding Children and Young People

2.181 Somerset CCG has a duty to ensure that all statutory requirements for safeguarding as defined in the 'Safeguarding Vulnerable People in the Reformed NHS; Accountability and Assurance Framework' (2015), Section 11 of the Children Act 2004 and 'Working Together to Safeguard Children (2015) are in place in all providers of NHS care. This requires all commissioned health services to have comprehensive systems and processes in place to safeguard and protect the children and young people from abuse and neglect, whilst improving the outcomes and experiences for children, young people and families.

2.182 This is achieved by ensuring that all NHS providers:

- provide a positive experience of care
- ensure treatment and care for children, young people and their families is provided in a safe environment where they are protected from avoidable harm
- have arrangements in place to ensure staff are trained and competent to identify children and young people who may be at risk of or experiencing abuse and are taking appropriate action to safeguard and protect them

- are raising awareness of potential signs and symptoms of abuse or neglect, especially in relation to child sexual exploitation, in light of learning from a recent Serious Case Review within Somerset
- ensure that the ongoing development of existing systems and processes in place for safeguarding and promoting the health and wellbeing of children and young people is influenced by the voice of the child

2.183 The CCG has continued to support improvements in Safeguarding Children in General Practices through provision of training and advice, and ensuring that primary care staff are involved in serious case reviews and learning events.

Serious Case Review

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

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

2.185 This Serious Case Review was published in December 2016. The CCG incorporated lessons to be learned from this review in a training day delivered to GP Safeguarding Leads.

2.186 In January 2016, a decision to initiate a serious case review (SCR) was made by the Somerset Safeguarding Children Board in accordance with the statutory guidance 'Working Together to Safeguard Children (2015). This review relates to disclosures of abuse by a number of individuals. It is still in progress and the CCG is working in partnership with all agencies across Somerset to identify the learning from this review.

Early Help

2.187 The CCG continues to work with the Local Authority to embed the Early Help offer across all agencies in Somerset. It is important for children, young people and their families to access services that can provide early intervention and help, so that the impact on the health and wellbeing of the child / young person is addressed at the earliest opportunity. All NHS Providers are supporting practitioners to undertake Early Help Assessments and the CCG is monitoring the increase in the use of these assessments through contract review meetings, each NHS provider's safeguarding committee and through the Quality and Performance sub group of the Local Safeguarding Children Board. The use of the local threshold document ('Effective Support for Children and Families in Somerset) in determining if an early help or safeguarding children referral is required was included in training provided to GP Safeguarding Leads.

2.188 Future development opportunities for Somerset CCG include:

- a baseline review of the CCG's safeguarding children team undertaken in March 2017 will inform the sustainability and transformation of this service.
- working in partnership with all agencies in Somerset to safeguard and promote the wellbeing of children and young people.
- reviewing the safeguarding children systems and processes in place for each of the NHS providers that we are lead commissioner for, through existing contract review meetings and each agency's safeguarding committees.
- monitoring the implementation of the action plan from the Serious Case Review published December 2016.

Infection Prevention and Control

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

Clostridium *difficile*

2.190 All NHS Trusts were set challenging trajectories for maintaining low number of Clostridium *difficile* cases acquired by patients in NHS hospitals. It has been confirmed by NHS England that these trajectories will remain the same for 2017/18. Providers are required to assess each trust attributed case to determine whether the case was linked with a lapse in the quality of care provided to the patient. Under the commissioning contract, lapses of care that have contributed will count towards the aggregate number of cases as the basis on which contractual sanctions are calculated.

2.191 Quarterly multi-disciplinary peer review meetings are held to review providers post infection reviews and agree whether or not a lapse of care that could have contributed to the case had occurred. The table below

shows the figures to the end of February for 2016/17. To help standardise this process a lapse in care tool has recently been tested and introduced.

Table 3:

Health Care provider	Trajectory for 2016/17	Figures up to end of February	Lapses in care *	Lapses in care TBC
Somerset Clinical Commissioning Group	106	72	NA	NA
Somerset Partnership NHS Foundation Trust	5	0	0	0
Taunton and Somerset NHS Foundation Trust	12	8	1	0
Yeovil District Hospital NHS Foundation Trust	8	9	2	4
TOTALS	**131**	**89**	**3**	**4**

* Final case numbers remain unconfirmed until peer review carried out in May 2017

2.192 Yeovil District Hospital NHS Foundation Trust was the only provider to exceed their trajectory. Post infection reviews identified that in three of their nine cases lapses of care had occurred that could have contributed to the case.

2.193 The overall C diff rate for Somerset CCG per 100,000 population from April 2016 to February 2017 was 16.5, which was the lowest rate for CCGs in the South West region (12 CCGs).

MRSA

2.194 NHS England continues to set healthcare providers the challenge of demonstrating a zero tolerance target for MRSA blood stream infections for patients through a combination of good hygiene, appropriate use of antibiotics, improved techniques in the care and use of medical devices as well as adherence to best practice guidance.

2.195 Somerset CCG has collaborated closely with the organisations providing patient care, to jointly identify and agree the possible causes of, or factors that contributed to, when patients have developed an MRSA bloodstream infection. To date in 2016/17, Somerset has reported six MRSA bloodstream infections during the year. The breakdown by organisation is detailed in Table 4 below.

Table 4:

Health Care provider	Number of cases 2016/17	Organisation assigned	Third party assigned *	Assignment TBC
Somerset Clinical Commissioning Group	5	1	2	2
Somerset Partnership NHS Foundation Trust	0	0	0	0
Taunton and Somerset NHS Foundation Trust	1	1	0	0
Yeovil District Hospital NHS Foundation Trust	1	0	1	0
TOTALS	**7**	**2**	**3**	**2**

* A third party assignment refers to cases where the Regional Medical officer (or their designated nominee) has agreed that, following a detailed review, the case could not be attributed to either the provider or the CCG

2.196 The overall MRSA rate for Somerset CCG per 100,000 population from April 2016 to February 2017 was the 6th lowest rate for CCGs in the South west region (12 CCGs).

Challenges and Ambitions for 2017/18

- E coli blood stream infection reduction will be a key area for focus in 2017/18. NHS England has set a target of a 50% reduction by 2020, with a 10% reduction in 2017/18. Reductions are linked to the Quality Premium payments
- the majority of E coli blood stream infections occur in the community with urine being the most common focus
- Somerset CCG currently has a rate of 78.6 cases per 100,000 population, which is the highest rate in the SW region
- a multi-disciplinary cross county wide action group has been set up to formulate and action a reduction plan, which will be monitored at the Somerset Infection and Prevention Assurance Committee

DEVELOPING THE SOMERSET SUSTAINABILITY AND TRANSFORMATION PLAN

2.197 Somerset CCG together with our partners aspire to be a true 'place based system of care' and has now committed with our other system senior leaders to move to an Accountable Care System for Somerset by 2019. This will not distract us from the current imperatives but signals our shared understanding that the health and care system in three years will be radically different. 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.

2.198 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. The Somerset Together programme which will introduce Outcome Based Commissioning will support this. It will also encourage the achievement of outcomes which are important to our patients and service users. This together with new models of care being tested out across the county, in particular the Primary and Acute Care (PACs) system model through the Vanguard Programme in South Somerset will support Somerset to achieve the long term vision of person centred and coordinated care.

2.199 The Sustainability and Transformation Plan demonstrates the case for change within Somerset against the three gaps identified within the Five Year Forward View. We know services in Somerset 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.

2.200 Quality is seen as the golden thread throughout the Sustainability and Transformation plan, covering the following system wide agreed definitions:

- **Safety:** people are protected from abuse and harm
- **Effectiveness:** people have access to proven treatment and care
- **Caring and responsive:** services respond to peoples' needs and preferences caring for people with compassion, dignity and respect
- **Person Centred:** personalised co ordinated services responding to what matters to individuals

2.201 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

STATUTORY RESPONSIBILITIES

Patient, Carer and Public Engagement

2.202 Between April 2016 and March 2017, the CCG undertook a range of public engagement through the following conduits.

2.203 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. In addition to scrutinising specific commissioning projects, in 2016/17 SEAG took on a new role as part of the Sustainability and Transformation Plan public engagement workstream, which has been formalised in its terms of reference.

2.204 SEAG has continued to both challenge and support the CCG in widening participation and addressing the equality and diversity agenda. In October 2016, a SEAG development day was convened with a view to enabling a wider range of people to find out about and get involved in health and social care commissioning. Workshops were facilitated by existing SEAG members, lay users, PPG chairs and Healthwatch volunteers, who set out examples of how they had become involved and the difference they had made. During 2016/17, SEAG has also developed stronger links with the County Council's service users' engagement group in an effort to reduce duplication and increase joint working on public engagement.

2.205 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 2016/17, the network has been briefed and fed back to the CCG on a range of areas, including the Primary Care Strategy, the Somerset Together programme, the Sustainability and Transformation Plan (STP), Patient Initiated Follow-Ups (PIFU), Somerset Doctors Urgent Care (SDUC), My Life Plan, the Somerset Digital Roadmap, the Care.data programme, Patient Online Access (POLA), the CCG Annual Review, and Carers Participation and Vision Groups.

2.206 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. These three representatives have a standing item on the network agendas, where they report back and capture feedback. The CCG has been working proactively with the new chair of the network, elected in October 2016, to plan how best to utilise the skills and motivation of network members and to ensure that the network works strategically with the CCG.

2.207 Health Forum meetings continue to be held three times a year in seven of the nine geographical patches of the county, bringing together a range of

community stakeholders, including GP surgeries, voluntary organisations and local councillors. Over twenty forum meetings took during 2016/17, covering a range of issues, including mental health, community connectors / village agents, public health projects, commissioning updates, prescribing policy changes, and complaints procedures.

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

- a weekly e-bulletin, summarising engagement opportunities, circulated to 300 people
- established links with voluntary organisations, including advocacy services, through whom community intelligence can be collected
- strategic use of Healthwatch feedback, which is regularly included in the CCG's quarterly patient experience reports
- use of Healthwatch Enter and View volunteers on the CCG's quality assurance visits to providers, bring a patient's perspective to bear on commissioned services
- the use of individual patient or carer experiences to raise issues and highlight learning at CCG Governing Body meetings

Equality and Diversity

2.209 The CCG engagement team lead the Somerset EDS Group which enables the CCG, County Council, service providers and other stakeholders to work together, exchange information and good practice, and support each other in the implementation of the Equality Delivery System, the Workforce Race Equality Standard and the Accessible Information Standard across Somerset. The 2015-16 Equality Delivery System Evidence and Grading Report was compiled in April 2016. Incorporating feedback from SEAG members, the final report was published on our website:
http://www.somersetccg.nhs.uk/about-us/how-we-do-things/equality-and-diversity/delivering-equality-and-diversity/
Evidence for the 2016/17 EDS report is currently being collected and a n updated EDS report will be published in the new financial year.

2.210 Key achievements in this work area in 2016/17 include:

- individual patient and carer experiences have been used as part of Governing Body training and development sessions and to highlight lessons at CCG Governing Body meetings. This has raised awareness and increased understanding of particular issues and barriers faced by people with a number of protected characteristics, including children and families with special needs or long term conditions, patients receiving end of life services and their carers, LGBT patients, patients with mental health issues and learning disabilities

- work has been done to look at ways in which both quality and equality can be impact-assessed together and in relation to each other. A checklist is being developed to improve CCG corporate practice in using equality impact assessments to inform and shape commissioning

- a SEAG development day was held in October 2016 to support a wider range of people to participate as lay users, volunteers, PPG members, and Healthwatch members. Work to widen participation will continue through SEAG and other mechanisms

Ensuring Staff Engagement within the CCG

2.211 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.

2.212 A number of key engagement opportunities are in place for staff:

Engaging with Partners

2.213 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 supporting commissioning.

2.214 In 2016 Somerset CCG invited 114 stakeholders to respond to the survey, including Member Practices, The Local Authority, NHS Providers, Patient Groups and Organisations. A really high response rate of 79% was achieved. The responses were positive overall with the majority of questions receiving a positive response. Many questions (55%) also saw an improvement on 2015.

2.215 An action plan was developed to support the survey results which included a number of items including amongst other things a commitment to feedback on the actions taken when concerns about quality are reported, increase engagement with GP Practices Managers, improve communication about CCG finances and to continue with the engagement forums which were already in place.

Staff Forum

2.216 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

2.217 The staff forum has recently been involved in the development of Engagement Events around forthcoming changes to the Health and Social Care System in Somerset. The purpose of the events is to engage with staff about the changes and provide everyone with the opportunity to get involved at an early stage. 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

2.218 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

2.219 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

2.220 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.

Staff Non-Executive Director

2.221 We have a dedicated Non-executive Director that is a staff champion and is involved with staff engagement across the CCG. She is also the CCG Raising Concerns champion.

Sustainability

2.222 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.

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

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

Emergency Planning

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

2.225 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 2016/17 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in Somerset.

2.226 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.

Health and Wellbeing Board

2.227 The CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2017:

Member	Organisation
Cllr Ann Bown (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr William Wallace	SCC
Cllr Anna Groskop	SCC
Cllr Ross Henley	SCC
Cllr 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	Somerset CCG
Lou Evans	Somerset CCG
David Slack	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

2.228 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 2016/17 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 and
- to increase use of licencing powers to promote health wellbeing and reduce harm

2.229 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. The CCG's plans for the 'Somerset Together' project have been endorsed by the Health and Wellbeing Board.

Risk Management

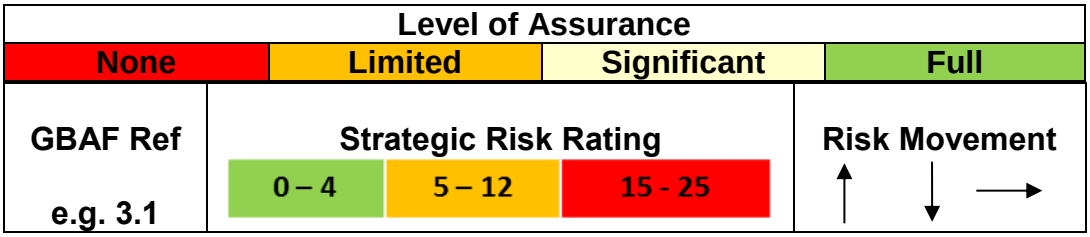
2.230 The CCG's policy and approach to risk management is set out in detail in section 5 of the Governance Statement. The risk management and assessment process underpins the successful delivery of the CCG's strategy, achievement of its objectives and the management of its relationships with key partners.

2.231 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

2.232 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.

The chart below sets out the CCG strategic risks and the associated ratings as at the end of March 2017. The key to explain the boxes in the chart is as follows which includes the references and ratings applied in the GBAF:

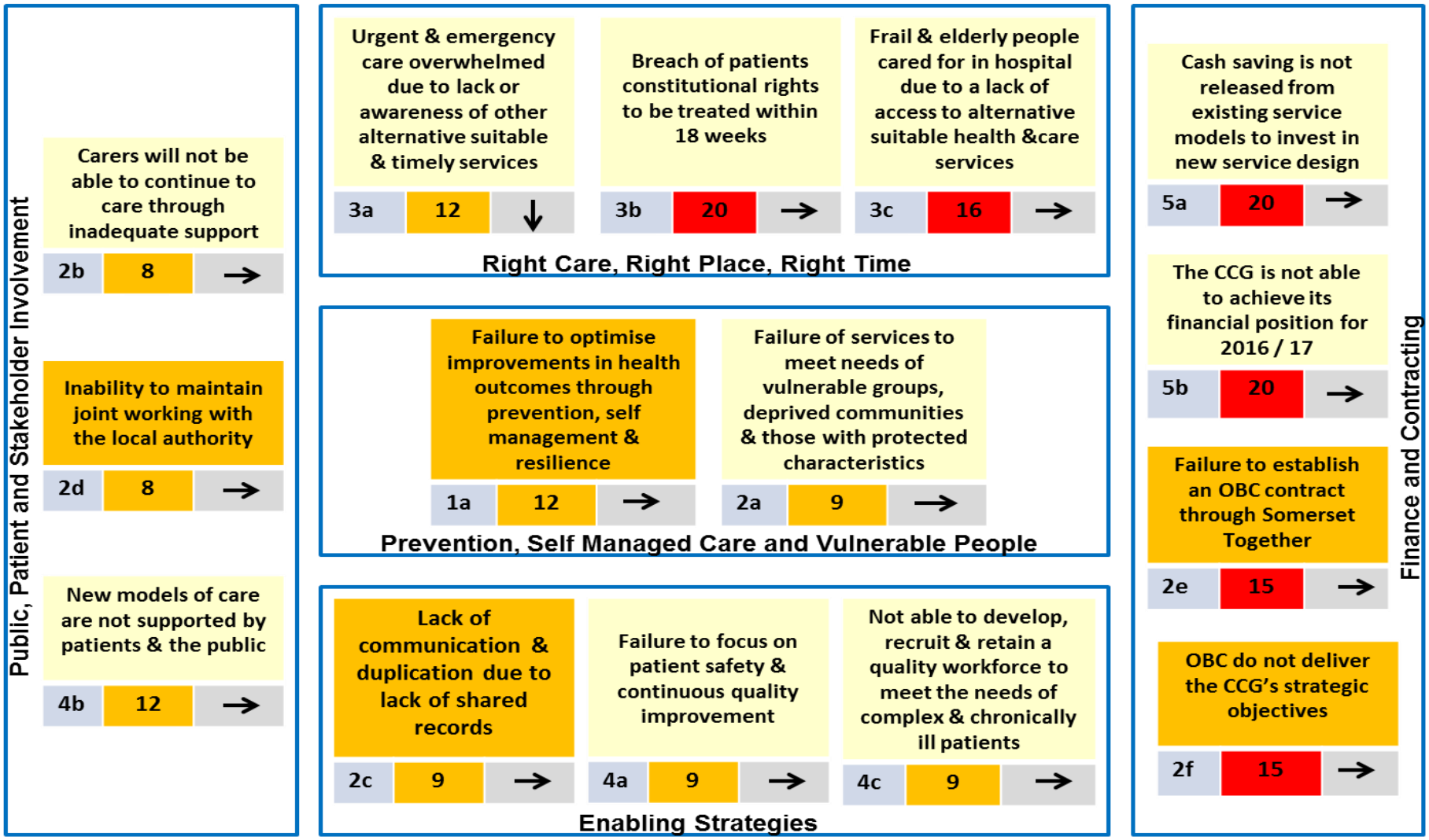


Notes:

The level of assurance reflects how confident the Governing Body is in the effectiveness of the controls to manage the risks effectively. The strategic risk is stated in the box and the background colour reflects the level of assurance.

The strategic risk rating is a calculation of the likelihood of the risk materialising against the impact it will have on the CCG's ability to deliver its strategic priorities. The risk rating score is stated in the box with the related 'red-amber-green' colour coding in the background.

Somerset CCG Strategic Risks



FINANCIAL AND PERFORMANCE ANALYSIS

Finances

2.233 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 2016/17 issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2016/17 financial statements.

Operating and Financial Performance

Financial Duties

2.234 During 2016/17, Somerset CCG did not meet all its financial duties.

2016/17 Target Performance	Achieved
Expenditure not to exceed income	✗
Capital resource use does not exceed the amount specified in Directions	✓
Revenue resource use does not exceed the amount specified in Directions	✗
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	✓
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	✗
Revenue administration resource use does not exceed the amount specified in Directions	✓

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

Overview

2.236 For the first time, in its fourth year in operation (1 April 2016 to 31 March 2017), Somerset CCG did not deliver all of its financial targets and delivered a deficit of £3,016,000 against its resource limit of £723,484,000.

Analysis of Revenue Performance

	2016/17 £'000
Revenue resource limit	723,484
Overspend against revenue resource limit	(3,016)
Percentage overspend against revenue resource limit	-0.4%

2.237 Somerset CCG planned to deliver an under spend of £6,484,000 for 2016/17 representing 0.9% of the total funding allocation, against the portfolio of services it commissions, as agreed with NHS England. The

position delivered was £9,500,000 distance from plan, the key reasons being an increase in emergency admissions, the national decision to uplift Funded Nursing Care rates and an overspend against the Learning Disabilities Pooled Budget.

2.238 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.

2.239 This plan represents the first year of the emerging whole system Sustainability and Transformation Plan. The Financial Framework for 2016/17 is underpinned by the vision of the Somerset CCG, namely:

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

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

2.241 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.

2.242 During 2016/17, monthly financial reports were regularly presented to the Somerset CCG Governing Body highlighting the in-year performance and forecast year end outturn.

2.243 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

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

2.245 The following summary financial statements are an extract from the Somerset CCG's Annual Accounts for 2016/17, and describe how Somerset CCG used its resources to deliver health services to residents of Somerset during 2016/17. An explanation of the key financial terms can be found on pages 76-77.

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

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

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

SUMMARY FINANCIAL STATEMENTS

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2017

2.247 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 2017

	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	(2,000)	(2,231)
Other operating income	(1,058)	(1,390)
Total operating income	**(3,058)**	**(3,621)**
Staff costs	7,454	6,152
Purchase of goods and services	721,065	695,347
Depreciation and impairment charges	78	37
Provision expense	358	708
Other Operating Expenditure	603	557
Total operating expenditure	**729,558**	**702,801**
Net Operating Expenditure	**726,500**	**699,180**
Finance income		
Finance expense	0	0
Net expenditure for the year	**726,500**	**699,180**
Net Gain/(Loss) on Transfer by Absorption	0	0
Total Net Expenditure for the year	**726,500**	**699,180**
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		
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 2017	**726,500**	**699,180**

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

Going Concern

Introduction

2.249 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.

2.250 Within the accounts, the CCG is required to make a clear disclosure that the individuals responsible for financial governance for the CCG have considered this position, and that given the facts at their disposal, the CCG is a 'going concern''. Where there are material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the CCG, these should be disclosed as part of the disclosure notes supporting the annual accounts.

2.251 The Department of Health Group Accounting Manual for 2016/17 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) (5.2.8) 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 should prepare their financial statements on the going concern basis unless, after discussion with their sponsors, the going concern basis is deemed inappropriate

- where an entity ceases to exist, it should consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements.

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

Criteria

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

2.254 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.

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

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

- forecast and budgets
- timing of cash flows
- contingent liabilities
- products, services and markets
- financial and operational risk management
- financial adaptability
- documentation

2.257 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 2016/17

Outturn

2.258 The financial outturn for 2016/17 is a deficit of £3.016m (-0.4%) against the plan agreed with NHS England of a surplus of £6.484m, therefore a deficit to plan of £9.5m. This represents a significant deterioration from the original plan, primarily due to increased activity within local acute providers who are now on Payment by Results contracts together with

significant in year cost pressures, including a 40% increase in funded nursing care fees. 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.

Interim Two Year Operational Financial Plan 2017/18 and 2018/19

2.259 The CCG Governing Body approved interim financial plans for 2017/18 and 2018/19 at its meeting on 30 March 2017.

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

2.261 To support the delivery of the STP and the operational plan, a Risk and Investment pool has been agreed between the Clinical Commissioning Group and the three Somerset NHS Foundation Trusts.

2.262 For both years, the interim plan does not deliver the full CCG business rules. The financial business rules requires a 1% surplus to be achieved, however due to the financial constraints within the Somerset system, NHS England has not requested that the Clinical Commissioning Group deliver the full business rules in 2017/18 and 2018/19, however the CCG needs to work towards recovery of the financial position.

2.263 The interim plan does not deliver to the control totals issued by NHS England for 2017/18 or 2018/19. Further discussions are being held between the Somerset STP leaders, NHS England and NHS Improvement in respect of the actions required to close this gap in 2017/18 and 2018/19.

2.264 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 Risk and Investment Pool
- continued targeted governance including a monthly executive CCG Finance Group chaired by the Vice-chair and a capability and capacity assessment of executive Directors to deliver the overall strategy
- in year application of any remaining contingency

2.265 The CCG has based its interim plan for 2017/18 on published notified allocation of £708.2m including the Better Care Fund allocation, together with the further known adjustments that have not yet been formally notified, but are part of the latest national financial model as follows:

- Running cost allocation - £11.9m
- PMS Funding - £2.2m
- Identification Rules Adjustment - £2.6m
- Price Change Adjustment – (£4.8m)

The overall Revenue Resource Limit is therefore £720.1m.

2.266 Further actions awaiting consideration from NHS England and are shown below:

- a formal request has been to NHS England to review the reduction in allocation made for the change in the national tariff pricing structure. The CCG has submitted a claim for £5.3m to be returned to the CCG in 2017/18 to more accurately reflect the actual impact of this change

- discussions are ongoing with NHS England regarding the application of the remaining 50% headroom funding (£3.5m) in 2017/18. This is on the basis that the collaborative risk process agreed across the health economy places a different approach to managing in year variances from plan, however this has not been agreed at plan

- ongoing discussions with NHS England through the planning process to agree the in year authorised spend level against the control total

2.267 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

2.268 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.

2.269 No account has been made for the impact of Primary Care Co-Commissioning or transfer of services from specialist commissioning during 2017/18.

2.270 The financial plans for 2017/18 have been based on a number of planning assumptions, which have in turn been taken from national planning guidance and local decisions.

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

2.272 The impact of the above is that the CCG faces a financial challenge of £15.5m in 2017/18 and £4.1m in 2018/19. QIPP schemes are well developed and are planned to save £31.6m and in addition Somerset Providers have a Cost Improvement Programme totalling £26.5m.

Cash Flow

2.273 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 2016/7 and is planning to do so on an on-going basis.

Contingent Liabilities

2.274 The contingent liabilities in 2016/17 relate to Continuing Healthcare and Her Majesty's Revenue and Customs.

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

Services

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

Risks and Adaptability

Investment and Risk Shared Pool

2.277 For 2017/18, the NHS organisations in the local health system have signed up to an Investment and Risk Shared Pool.The partners are:

- Taunton and Somerset NHS Foundation Trust
- Yeovil District Hospital NHS Foundation Trust
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group

2.278 The principles under which this pool will be administered are based on the 14 'Must Do' principles as agreed within the Somerset Sustainability and Transformation Plan.

2.279 The formation of this agreement starts the system journey towards an Accountable Care System model for Somerset and moves away from payment on a PbR contractual basis towards a shared capitated based budget.

2.280 The pool works as a risk share to ensure the delivery of QIPP and mitigation of cost pressures through partnership working and also provides a vehicle to agree transformational investment by partners through allocating a fair share of both costs and associated savings.

2.281 All CCG commissioning budgets are within the scope of this pool and any improvement or deterioration against CCG planned budgets will be subject to the risk shares noted below:

- Taunton and Somerset NHS Foundation Trust 26%
- Somerset Partnership NHS Foundation Trust 18%
- Yeovil District Hospital NHS Foundation Trust 11%
- Somerset Clinical Commissioning Group 45%

2.282 This allocation of risk across the system incentivises the system to work in partnership to ensure that the current plans submitted to NHS England are delivered in full to avoid further costs into their own organisations.

2.283 The full governance arrangements are currently being finalised between partners and will be in place prior to 1 April 2017. An initial meeting of the Somerset Health Partners Risk Share Management Board is due to take place during April 2017.

Planning Assumptions

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

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

Quality, Innovation, Productivity and Prevention (QIPP) Schemes

2.286 As highlighted about the interim plan for 2017/18 is underpinned by the requirement to deliver £31.6m savings during 2017/18, and in addition Somerset Providers have a Cost Improvement Programme totalling £26.5m. There is risk in the timelines for delivery of these schemes which could result in the full benefits not being realised during 2016/17.

In year volatility

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

2.288 A risk in respect of expenditure on continuing healthcare also remains. The programme spend for 2017/18 taken into account growth assumptions but a risk remains the actual levels of growth are higher than anticipated.

Documentation

2.289 The Governing Body receive regular reports on the financial performance of the CCG which gives considerable assurance and documentary evidence of performance. Additional reporting of the Somerset System Financial Position will be received by the Somerset Health Partners Risk Share Management Board to obtain system assurance of the Somerset System Financial Position Other documentation includes risk register reviews, Draft Financial Plan, Final Financial Plan, monthly QIPP reports and ad-hoc reports and information as required. The CCG also submits quarterly information to NHS England as part of the CCG assurance process.

2.290 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

2.291 Having considered the position as set out above, it is recommended that management prepare the annual accounts for 2016/17 on a going concern basis.

Revenue Resource Limit

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

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

2.294 The Somerset CCG performance for 2016 /17 is as follows:

	2016/17 £'000
Total net operating cost for the financial year	726,500
Final revenue resource limit for the year	723,484
Under/(over) spend against revenue resource limit	**(3,016)**

2.295 This table highlights that, in 2016/17 Somerset CCG overspent by £3,016,000 representing 0.4% of the Somerset CCG's resource limit.

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2017

2.296 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 2017

	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 between reserves in respect of assets transferred from closed NHS bodies	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 expenditure 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	**(726,500)**	**0**	**0**	**(726,500)**

Financial Year				
Net funding	721,618	0	0	721,618
Balance at 31 March 2017	**(29,839)**	**0**	**0**	**(29,839)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(24,826)**	**0**	**0**	**(24,826)**
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 2016	**(24,826)**	**0**	**0**	**(24,826)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(699,180)			(699,180)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(699,180)**	**0**	**0**	**(699,180)**
Net funding	699,049	0	0	699,049
Balance at 31 March 2016	**(24,957)**	**0**	**0**	**(24,957)**

2.297 This statement records the movements in reserves for the year ended 31 March 2017.

Statement of Financial Position as at 31 March 2017

2.298 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 2017

	Note	**2016-17** £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	13	370	394
Intangible assets	14	13	17
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		383	411
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	7,684	5,487
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	49	50
Total current assets		**7,735**	5,539
Non-current assets held for sale	21	0	0
Total current assets		**7,735**	5,539
Total assets		**8,118**	5,950
Current liabilities			
Trade and other payables	23	(37,178)	(29,997)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(779)	(910)
Total current liabilities		**(37,957)**	(30,907)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(29,839)**	(24,957)
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		**(29,839)**	(24,957)
Financed by Taxpayers' Equity			
General fund		(29,839)	(24,957)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(29,839)**	(24,957)

2.299 This statement records the assets and liabilities of Somerset CCG as at 31 March 2017.

Statement of Cash Flows for the Year Ended 31 March 2017

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

Statement of Cash Flows for the year ended 31 March 2017

	Note	**2016-17 £'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(726,500)	(699,180)
Depreciation and amortisation	5	78	37
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	(2,197)	(164)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	7,433	(130)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(489)	(320)
Increase/(decrease) in provisions	30	358	708
Net Cash Inflow (Outflow) from Operating Activities		**(721,317)**	(699,049)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(302)	0
(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		**(302)**	0
Net Cash Inflow (Outflow) before Financing		**(721,619)**	(699,049)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		721,618	699,049
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		**721,618**	699,049
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(1)**	0
Cash & Cash Equivalents at the Beginning of the Financial Year		**50**	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		**49**	50

2.301 This statement records the movement in cash between 1 April 2016 and 31 March 2017. For 2016/17, the Somerset CCG's cash balance was £49,000.

Better Payment Practice Code

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

2.303 The Somerset CCG's performance for the year ended 31 March 2017 is summarised below:

Measure of compliance	2016-17 Number	2016-17 £000	2015-16 Number	2015-16 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**20,076**	**124,357**	15,480	112,703
Total Non-NHS Trade Invoices paid within target	**20,026**	**124,242**	15,386	111,739
Percentage of Non-NHS Trade invoices paid within target	**99.75%**	**99.91%**	99.39%	99.14%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,617**	**499,887**	3,289	490,873
Total NHS Trade Invoices Paid within target	**3,604**	**499,860**	3,230	485,076
Percentage of NHS Trade Invoices paid within target	**99.64%**	**99.99%**	98.21%	98.82%

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

Cash Limit

2.305 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 £721,618,007 (99.4%) against a cash limit of £726,117,864 meeting this requirement.

Running Costs

2.306 The CCG was funded £11.873 million, equating to £21.07 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 £3,391,000 which covers Commissioning Delivery Support, Organisational Support, Referral and Booking Management Service and GP IT Services. Expenditure recorded against running costs for 2016/17 totalled £11.108 million.

Accounting Policies

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

Governing Body and Clinical Operations Group Members

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

External Audit

2.309 The Grant Thornton UK LLP is the appointed external auditor for the Somerset CCG. The total fee paid to Grant Thornton UK LLP in 2016/17 was £85,500 including VAT to cover the cost of the statutory audit and associated services.

Governance Statement

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

2.311 A copy of the full Governance Statement is included in section 3.11 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

2.312 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 not assured. As Quarter 3 2016/17 Somerset Clinical Commissioning Group has been assessed as requires improvement.

2.313 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. Where performance has not met either the national standard or locally agreed improvement trajectories contractual levers have been enacted by way of serving Contract Performance Notices.

2.314 2016/17 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 since October 2016.

2.315 Somerset CCG has continued to work closely with both main providers in order to reduce the number of patients who wait longer than 18 weeks from referral to treatment (RTT) and monitoring the progress against agreed improvement plans. A commissioner RTT Improvement Plan was developed during 2016/17 with the primary focus upon increased utilisation of the Independent Sector and implementation of effective demand management schemes with the latter being shared by NHS England as an exemplar. The 92% incomplete pathway operational standard was recovered at Yeovil District Hospital NHS Foundation Trust in January 2017 and whilst performance continues to be challenged at Taunton and Somerset NHS Foundation Trust the admitted waiting list is at its lowest level since March 2016.

2.316 The system significantly improved the performance against the diagnostic standard ie. that 99% of patients should wait less than six weeks for a diagnostic tests or procedure. Following a prolonged period of breach at Taunton and Somerset NHS Foundation Trust; although the operational standard is not being met due to ongoing challenges in MRI and Endoscopy, as a result of focused works the waiting times within Audiology have largely recovered. In March 2017 the proportion of Somerset patients awaiting a diagnostic test or procedure was at its lowest level since March 2014.

2.317 We achieved five of the nine cancer standards in 2016/17, recovering the 2 week suspected cancer standard but under achieving the breast symptoms and 62 day waiting time cancer standards.

Performance Analysis

2.318 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.

2.319 As part of the Five 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.

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

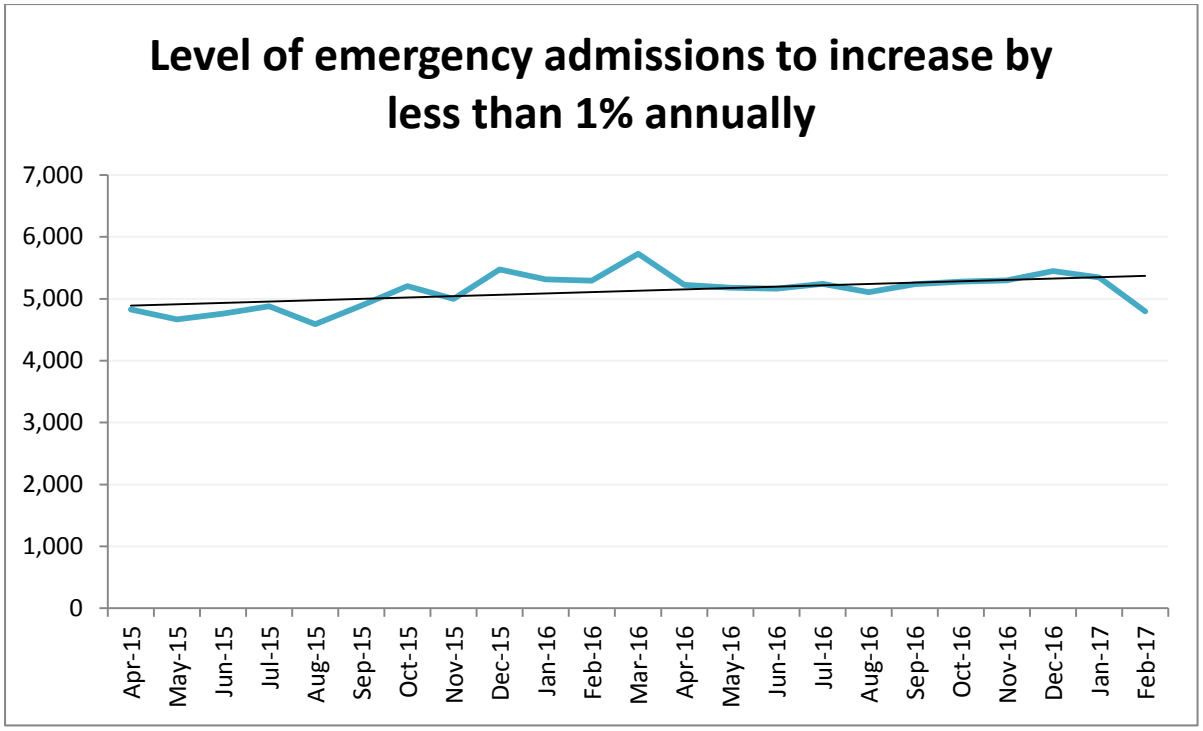
2.321 The performance delivered in respect of emergency and urgent care during the reporting period 1 April 2016 to 31 March 2017, for Somerset residents is set out below:

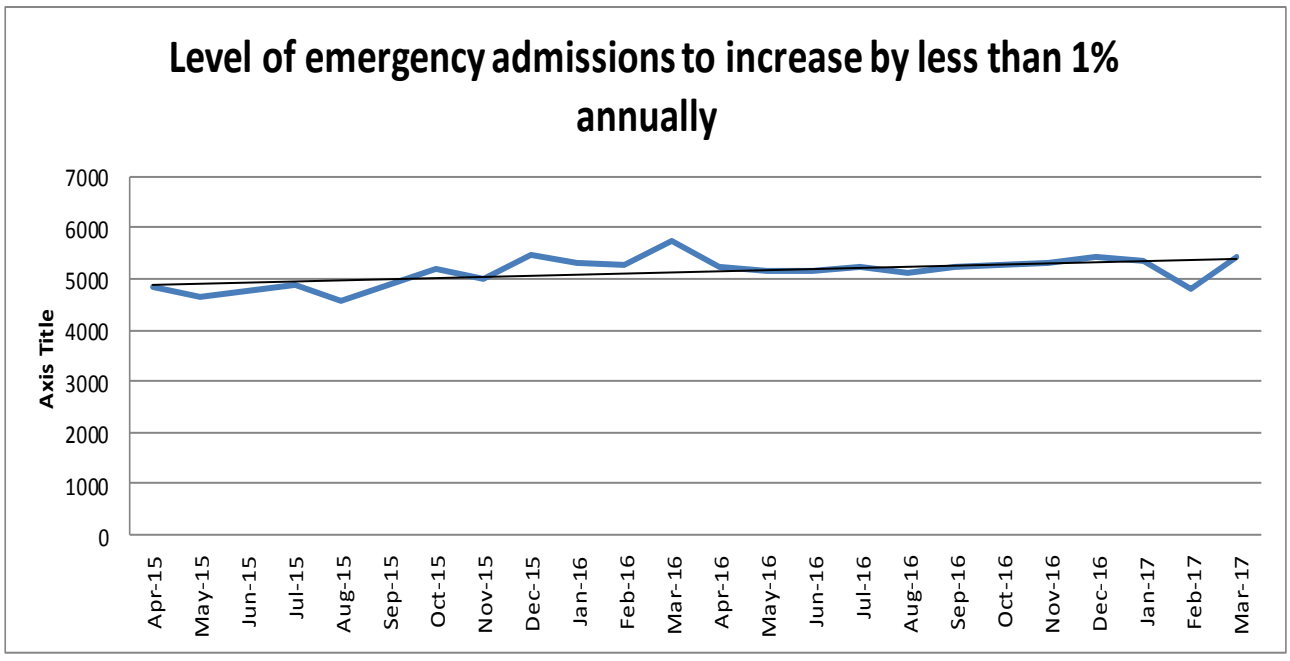
Emergency and Urgent Care Performance Scorecard between 1 April 2016 and 31 March 2017

Emergency Care	Standard	Achievement	Variance +/(-)
Cumulative percentage of patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95.00%	94.14%	-0.87%
Percentage of ambulance handovers to A&E department within 30 minutes	100.00%	93.58%	(6.42%)
Percentage of ambulance handovers to A&E department occurring between 30-60 minutes	0.00%	6.02%	6.02%
Percentage of ambulance handovers to A&E department over 60 minutes	0.00%	0.40%	0.40%
Level of emergency admissions to increase by less than 1% annually	1.00%	3.53%	2.53%
Operations cancelled at the last minute offered another admission date within 28 days	100.00%	94.01%	(5.99%)
Percentage of people admitted directly to a stroke unit within 4 hours of hospital arrival	80.00%	61.06%	(18.94%)

2.322 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 2016-17 with Yeovil District Hospital NHS Foundation Trust (with the exception of December 2016) recovering the operational standard from October 2016 and performance at Taunton and Somerset NHS Foundation Trust incrementally improving during Quarter 4 with performance of 93.9% reported in March 2017 and coinciding with a reduction in ambulance handover delays during the same period.

2.323 The number of emergency admissions has increased by 3.53% and this level of growth represents an improvement upon the growth seen in the previous year. The most notable areas of growth are within the under 5's age cohort as well as an increase in the number of older persons zero length of stay admissions. (Taunton and Somerset NHS Foundation Trust fully implemented their OPEL unit in 2016-17 and Yeovil District Hospital has a fully established FOPAS unit, and will be a factor when assessing the growth in admissions). The increase from April 2015 to March 2017 is shown below.





2.324 A number of opportunities to reduce the number of emergency admissions and consumed bed days have been identified by RightCare and work streams have been established in order to realise these opportunities and improve operational performance in 2017/18.

Ambulance Response Times

Percentage of Category A calls receiving a response from South Western Ambulance Service NHS Foundation Trust for the period 1 November 2016 to 31 March 2017

Standard	Target	Trust-wide Performance	Performance in Somerset
Cat 1 Response within 8 minutes	75.00%	72.77%	68.66%
Cat 1 Transport Response within 19 minutes	-	83.78%	82.78%
Cat 2 Response	-	13.97%	17.07%
Cat 2 Transport Response	-	86.03%	82.93%

2.325 During 2016/17 South Western Ambulance Service NHS Foundation Trust has been participating in an Ambulance Response Programme (ARP) in order to improve response times to critically ill patients through more appropriate use of triage time. The former Red 1 and Red 2 ambulance response time standards were replaced by a single Red standard in April 2016 and this was replaced by the new Category 1 standard during late October 2016, with the same commitment that 75% of calls would be responded to within eight minutes.

2.326 During the period November 2016 to March 2017 on a cumulative basis performance of 68.66% was delivered against the 8 minute national target of 75%.

Waiting Times for Cancer Treatment

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

- 93% of patients to be seen within two weeks of referral
- 96% of patients' first treatments to be within 31 days or less from the decision to treat
- 98% of patients second or subsequent treatments by anti-cancer drug treatments, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by surgery, within 31 days or less from decision to treat
- 94% of patients second or subsequent treatments by radiotherapy, within 31 days or less from decision to treat
- 85% of patients' first definitive treatment will be within 62 days from urgent GP referral to their first definitive treatment

- 90% of patients' first definitive treatment will be within 62 days from cancer screening programme or consultant upgrade to their first definitive treatment

2.328 The performance scorecard in respect of the cancer waiting times standards achieved for services and Somerset patients, for the period 1 April 2016 to 31 March 2017 is shown below

Waiting Times Standard	Standard	April 2016 – March 2017	Variance
		Number inside standard	+/(-)
% of patients referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment	93.00%	93.26%	0.26%
% of patients referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment	93.00%	92.67%	(0.33%)
% of patients waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers	96.00%	97.32%	1.32%
% of patients waiting no more than 31 days for subsequent treatment where that treatment is surgery	94.00%	94.53%	0.53%
% of patients waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen	98.00%	99.84%	1.84%
% of patients waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	94.00%	97.68%	3.68%
% of patients waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer	85.00%	81.49%	(3.51%)
% of patients waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers	90.00%	87.34%	(2.66%)
% of patients waiting no more than 62 days from referral from consultant upgrade to first definitive treatment for all cancers	90.00%	83.40%	(6.60%)

2.329 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.

2.330 During the period April 2016 to March 2017 five of the nine standards were delivered for Somerset patients, and despite an increase in demand the 2 week suspected cancer standard was recovered but there continued to be challenges in respect of delivery of the 62 day standard. This was

underpinned by an increase in the number of complex cases requiring treatment outside of Somerset, the impact of the new national breach allocation rules and the closure of the high volume skin cancer service at Taunton and Somerset NHS Foundation Trust. Both local Providers have 62 Day Cancer Improvement Plans in place in order to improve and sustain performance.

Referral to Treatment Pathways

2.331 The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2016 to 31 March 2017 is set out below.

Somerset Clinical Commissioning Group Key Performance Scorecard (Somerset Relevant Population) between 1 April 2016 and 31 March 2017

Indicator		Standard	% Achieved	Variance +/(-)
Referral to Treatment waiting times	% of patients on incomplete RTT pathways (yet to start treatment) waiting no less than 18 weeks from Referral	92.00%	89.01%	(2.99)
	Average Median waiting time (2014-15)	7.2 Weeks	6.59 Weeks	0.61 Weeks
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99.00%	95.23%	(3.77%)

Indicator		Standard	% Achieved	Variance +/(-)
Referral to Treatment waiting times	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no less than 18 weeks from Referral	92.00%	88.94%	(3.06)
	Average Median waiting time	7.2 Weeks	7.18 Weeks	0.02 Weeks
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99.00%	94.87%	(4.13%)

Referral to Treatment - Standards

2.332 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. As a result of focused backlog clearance Yeovil District Hospital NHS Foundation Trust recovered this standard from January 2017. Taunton and Somerset NHS Foundation Trust have under achieved this standard throughout 2016/17 but are receiving ongoing support from NHS Improvement's Very Intensive Support Team as they continue to progress the improvement actions under four separate work streams. The Trust have also continued to deliver the actions contained within their RTT Improvement Plan resulting in a reduction of the number of patients awaiting treatment and in March 2017 reporting the lowest level of admitted backlog since March 2016.

2.333 Somerset Clinical Commissioning Group continues to monitor progress against improvement plans and is working with all Providers to improve performance during 2017/18.

Diagnostic Waiting Times - Standards

2.334 The NHS Constitution standard for diagnostics is that 99% of patients should wait less than six weeks for diagnostic test or procedure and as at 31 March 17, 96.62% of patients on the waiting list had been waiting six weeks or less. The CCG significantly improved the performance against this standard during 2016/17 as a result of the improvement actions undertaken by Taunton and Somerset NHS Foundation Trust and the CCG continue to work closely with the Trust during 2017/18 to ensure they achieve operational compliance.

Self Certification by the Accountable Officer

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

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

Signed:

David Slack
Accountable Officer
Somerset Clinical Commissioning Group

Date: 25 May 2017

3 ACCOUNTABILITY REPORT

Corporate Governance Report

Members' Report

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

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

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

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

Breakdown of CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 2017

Name	Title	Committee Membership (voting and non-voting membership)						
		Governing Body	Clinical Operations Group	Audit Committee	Remuneration Committee	Governance Committee	Joint Committee (Primary Care)	Health and Well Being Board
CCG Executive Leadership								
David Slack	Managing Director/Accountable Officer	✓	✓			✓		✓
Alison Henly	Chief Finance Officer and Director of Performance	✓	✓			✓	✓	
Sandra Corry	Director of Quality and Safety	✓	✓			✓	✓	
Ann Anderson	Director of Clinical Commissioning Development	✓	✓			✓	✓	
Paul Goodwin	Director of Commissioning Reform and Governance	✓	✓					
GP Practice Clinical Leadership								
Dr Ed Ford	CCG Chairman and GP Locality Delegate, West Somerset	✓	✓			✓		✓
Dr Will Harris	Clinical Operations Group Chair and GP Locality Delegate, West Mendip	✓	✓			✓		✓
Daniel Vincent	GP Locality Delegate, South Somerset		✓					
Dr Alex Murray	GP Locality Delegate, Bridgwater Bay		✓					
Dr Geoff Sharp	GP Locality Delegate, Central Mendip	✓	✓	✓				
Dr Rob Allen	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		✓					

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

Statement of Accounting Officer Responsibilities

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

3.6 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)

3.7 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.

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

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

- make judgements and estimates on a reasonable basis

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

- prepare the financial statements on a going concern basis

3.9 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 financial duties under Sections 223H to 223J. This was due to the Clinical Commissioning Groups' expenditure exceeding income, exceeding its resource limit by £3,016,000.

3.10 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:

David Slack
Accountable Officer
Somerset Clinical Commissioning Group
Date: 25 May 2017

Governance Statement

Introduction and Context

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

3.12 As at 1 April 2016, the Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

Scope of Responsibility

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

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

Governance arrangements and effectiveness

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

3.16 Somerset CCG is a membership body comprising of 71 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 4 of its membership to the Governing Body.

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

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

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

a) Clinical Operations Group (COG)

b) Audit Committee

c) Governance Committee

d) Remuneration Committee

e) Joint Committee (Primary Care)

3.20 The remit of each committee is as follows:

Committee	Key roles and responsibilities
Clinical Operations Group (COG)	GP Clinical Lead: Dr Will Harris Executive Lead: David Slack 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: David Slack 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: Ann Anderson 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 work plan • oversee implementation of the CCG statutory duty to improve the quality of primary care

3.21 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. From these assessments, I am able to report that Somerset CCG has been regularly assessed as being an effective organisation.

3.22 There has also been self-assessment undertaken by the Governing Body and Leadership Team to review their effectiveness against the governance criteria developed by the Good Governance Institute and NHS England. The results have been discussed at Governing Body Development sessions and have informed the development of the Assurance Framework and further work going forward.

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

- established and effective working relationships to support commissioning responsibilities

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

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

3.25 In addition, the Somerset CCG has recently commissioned an independent review of the senior leadership team. The review includes both the Executive Directors and COG members and reflects both the short and longer term needs of the CCG.

3.26 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.

Compliance with the UK Corporate Governance Code

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

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

Discharge of Statutory Functions

3.29 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 2016/17 with appropriate legal advice and

approval by NHS England to reflect any changes to the organisational structure and responsibilities.

3.30 In light of recommendations of the 1983 Harris Review, the Clinical Commissioning Group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

3.31 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

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

3.33 The CCG Risk Management Framework is set out in the Risk Management Strategy and Policy. This policy supports the adoption of an open culture where individuals are encouraged to report adverse incidents and near misses, to ensure the CCG can use learning to continuously improve health services and the way in which these are commissioned to meet the needs of the population

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

- demonstrate an organisational risk management structure that details all the committees / sub-committees / groups / forums which have shared responsibility for managing risk across the organisation
- approve and monitor the risk management programme and the CCG's policies and procedures for the management of ris
- outline the process which ensures that the Governing Body undertakes a regular review of the Corporate Risk Register and Assurance Framework to provide assurance that the Governing Body of the CCG can deliver the strategic objectives
- demonstrate the development of a system for the implementation of seamless risk management strategies, in all areas of the organisation, including business planning and planned developments
- identify within the Risk Management Strategy, the documentation and process, roles and responsibilities of the key individual(s) in post

with responsibility for advising on and co-ordinating risk management activities

- identify within the Strategy documentation the respective roles, responsibilities and accountability undertaken by the executive, lead officers and non-executive leads for each area of risk

- identify the responsibilities of all managers and staff and their authority with regard to identifying, assessing and managing risk

- outline the process for risk assessment for all types of risk

- sets out the risk appetite of the CCG which is assessed against the its risk rating matrix

3.35 The annual work programme for both the Audit and Governance Committees are set based on a risk based approach and focus on:

- preventing risk
- deterring risks arising (eg. fraud deterrents) and
- managing current risks

3.36 This is detailed in the earlier sections of this report, which outlines the key responsibilities of the committees.

3.37 The annual work programmes are influenced by the key priorities and objectives of the CCG, and for the Audit Committee include an independent review by the Internal and External Auditors and Counter Fraud specialists.

3.38 The CCG regularly reviews the directorate risk registers and assurance framework to ensure any risks are being mitigated through robust and timely action plans. In addition, quarterly clinical quality review presented to the Governing Body highlights any themes of complaints of patient experience and actions plans are immediately developed with the provider organisations to ensure patient experience and outcomes are maximised.

Capacity to Handle Risk

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

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

3.41 An Executive Director and GP clinical lead are responsible for the committees listed earlier in this report.

3.42 The responsibility for any risks identified has a named Executive Director, including any actions required to mitigate the risk. The committees regularly review the risks and associated action plans to ensure they are being delivered in a timely manner and that this is addressing the underlying risk.

3.43 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.

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

3.45 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

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

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

3.48 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

3.49 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.

3.50 Each quarter the CCG's risk management team advise senior managers of a date by which to completed a review and update of their risk registers, in preparation for quarterly corporate risk register extraction. The corporate risk register is compiled through extraction from directorate risk registers and a moderation process. Each quarter the Head of Risk Management reviews with risk handlers (senior managers) their risk entries to ensure they are concise, 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.

3.51 Every quarter the resulting corporate risk register is presented to the Governance Committee. The committee actively uses this opportunity to review the CCGs risk profile and ensure appropriate actions are in place to mitigate identified corporate risks. Further moderation and action planning will be incorporated into the corporate risk register in preparation for use by the Governing Body. The overall aim being to enable most of the operational work to be conducted on behalf of the Governing Body in advance of their consideration each quarter of the corporate risk register.

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

- the CCG's financial budget and Quality, Innovation, Productivity and Prevention (QIPP) savings targets
- the financial impact arising from increases in demand and the associated activity in services for older and vulnerable people, such as continuing healthcare, services for people with learning disabilities and wheelchair services
- the impact on the quality and safety of services and compliance with constitutional rights arising from increased demand on urgent and emergency care services
- risks associated with the transition to a range of new services arising from a change in service provider following procurements
- the quality and safety of some services identified through CCG quality monitoring systems and / or through CQC regulatory inspections
- changing population demands on services and the plans and progress for the CCG towards adopting new models of care and service delivery arrangements, such as Outcome Based Commissioning

3.53 During the financial year 2016/17 the overall risk profile of the CCG has increased when compared to recent previous years. In 2015/16 very few risk during the year reached a score of above 12. When risk scores increased to above 12 they were quickly mitigated and reduced again. At the end of 2016/17 the CCG's corporate risk register retains 12 risks on the corporate risk register scoring between 16 and 20. The risks around meeting constitutional standards and financial balance have increased classification from moderate to major risk. The CCG was unable to sufficiently mitigate in these risk areas; meaning the risks were realised in a financial deficit and breaches in constitutional standards for access to services for a small, but significant proportion of patients seeking access to healthcare services in Somerset.

3.54 In addition to managing risk from an operational base, the CCG also assesses and manages strategic risk through its Governing Body Assurance Framework (GBAF). The Governing Body has identified and assessed which risks present the most significant challenge to achieving its strategic objectives.

3.55 In the same manner as the process for review of the corporate risk register, there is a parallel process for identification and review of the CCG's sources of control and assurance towards achieving the CCG's strategic objectives. Strategic risks are kept under review during the year, these have broadly fallen into the following areas:

- the readiness of patients, the public and health and care staff for adopting and encouraging heathier lifestyle choices to prevent and reduce the impact of disease and poor health on healthcare service provision
- separate but connected to the strategic risk of population health burden, the Governing Body have identified a need to manage risk around engaging with the public to understand the need for new models of care and service delivery
- ensuring people are not disadvantaged either through discriminatory and / or inequitable service arrangements for protected and / or vulnerable groups
- ensuring enhanced use and application of information and communication technology to support more efficient, effective and high quality service user experience in care and treatment delivery systems
- the need to maintain NHS constitutional standards in relation to timely and safe access to services
- the need to mitigate all of these strategic risks and to do so within the CCGs financial allocation

Other Sources of Assurance

Systems of Internal Control

3.56 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.

3.57 The CCG has an Equality Impact Assessment Policy in place which provides the framework to ensure compliance with our statutory obligations under the Public Sector Equality Duty 2010 s149, and to identify any risks to the 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.

3.58 The CCG has a Patient and Public Engagement Strategy in place that was revised and approved by the Governing Body in March 2016. There is a strong engagement network in place in Somerset through the Health

Forums for each Commissioning Locality, a network of Patient Participation Group Chairs and regular events to seek the views of patients and the public. There has been active engagement, in particular concerning the Somerset Together project and other key service consultations such as the Shepton Mallet Health Campus.

The Clinical Commissioning Group Internal Control Framework

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

3.60 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.

3.61 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.

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

3.63 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 2016/17.

3.64 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

3.65 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

3.66 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.

3.67 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.

3.68 Overall, the report raised seven recommendations relating to the CCG's management of conflicts of interests, including six medium level and one 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.

3.69 Each of the recommendations was implemented in March 2017 and an update will be provided to the Audit Committee on 17 May 2017.

Information Governance

3.70 The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

3.71 We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an Information Governance Management Framework and have put in place information governance processes and procedures in line with the information governance toolkit.

We have ensured all staff undertake annual information governance training and have provided guidance as appropriate to ensure staff are aware of their information governance roles and responsibilities. 98% of all staff had completed their information governance training by 31 March 2017.

3.72 Somerset CCG has submitted a satisfactory level of with the Information Governance (IG) Toolkit with an overall compliance rate of 79% for 2016/17 which is an increase from 75% in 2015/16. The clinical commissioning group has no requirements assessed as Level 0 or Level 1, fifteen at Level 2, nine at Level 3 and four 'Not Relevant'. Particular improvement to Level 3 status was made in areas including staff awareness of Information governance requirements, information risk policy, risk management strategy and confidentiality of service user information protected by use of pseudonymisation and anonymisation techniques, while at the same time maintaining previously achieved Level 3 requirements. The level of compliance reflects the sustained progress building upon the information governance structures and processes established when the CCG was established and provides a robust assessment of the progress to date. An improvement plan is in place to ensure that the work continues to develop and that compliance further improves during 2017/18 which will be monitored through the Information Governance, Records Management and Caldicott Committee. During 2016 NHS Digital also audited the CCG's toolkit submission and found it to be fully compliant.

Data Security

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

Data Quality

3.74 The CCG has continued to develop data quality in conjunction with the CSU during the 2016/17 financial year.

Data Sharing

3.75 The CCG was subject to an audit of data sharing activities by NHS Digital in January 2017. The report was published on the NHS Digital website in March 2017. The audit identified 4 minor non-conformities and 7 observations which have been taken forward and addressed through an action plan. The audit provided substantial assurance for information transfer and data use and benefits; moderate assurance for risk

management and operational management and control; and limited assurance for access control.

Business Critical Models

3.76 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

3.77 Control measures are in place to ensure that the CCG complies with the required public sector equality duty set out in the Equality Act 2010. The Governing Body approved a refreshed Equality and Patient Engagement Strategy in March 2016 which sets out how the organisation manages its obligations. The implementation of the strategy is monitored through the Governance Committee.

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

Third party assurances

3.79 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

3.80 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. 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 Statatics (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
- professional feedback from our GP membership through the GGC's Healthcare Professional Feedback system
- assurance visits to services by the CCGs commissioning officers
- 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 Microbiology and Infection Control Liaison Group and many more examples of shared work programmes

3.81 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

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

- the South West Commissioning Support Unit (CSU)
- NHS Property Services
- Somerset Partnership NHS Foundation Trust – for payroll service

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

3.84 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

3.85 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.

3.85 During 2016/17 Somerset CCG has been working 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). 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 2016/17 the extent of this activity has been limited to establishing a work programme to

deliver the aims and objectives of the STP. In 2017/18 work will need to be progressed to work towards a different assurance framework across and between participating agencies in the STP.

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

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

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

3.88 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

3.89 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

3.90 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

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

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

- improved corporate decision making through the high visibility of risk exposure, both for individual activities and major projects, across the whole of the organisation
- a progressive management style and a culture of continuous improvement that is enhanced by the encouragement of openness in relation to risk
- the objectives of the organisation and its stakeholders are more likely to be realised through the early identification and proactive management of threats to cost, time and performance
- the needs of corporate governance are met by embedding the management of risk processes which provide a clear message and directives
- there is a clear ownership and accountability for risks and their management so that they are effectively monitored and proactively managed
- financial benefit to the organisation through improved "value for money" potential and better management of project and programme finance
- management of project risk is carried out within the wider context of programmes, thus minimising the risk of individual project failure through greater visibility of the potential impact of other projects
- consistency of approach through high-level monitoring and direction
- creation of an environment for the conscious acceptance of business risk on an informed basis
- improved contingency plans and business continuity plans
- better awareness in all personnel of the cost and benefit implications of their actions

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

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

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

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

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

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

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

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

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

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

- Risk Management Strategy and Policy

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

3.100 At 31 March 2017 there were twelve 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 2016/17 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.

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

- failure of T&S FT to meet 18 week referral to treatment targets will impact adversely on patient experience
- risk of overspend or reduction in services to meet 2016-2017 budget provision
- YDH and TST contracts for 2016/2017 will be PbR funded which could increase costs if activity increases
- financial pressure if QIPP schemes unable to deliver targets
- CHC funding decision delays and experience for application
- access to OOH Service could be compromised by lack of full clinical rota in the SDUC service
- increased pressure on NHS 111 service meeting the 60 Second Call Response target
- future sustainability of services at Weston Area Health Trust
- delays for ambulances due to high levels of demand (i.e. Call Stacking) (Ambulance)

- increased demand on urgent care leading to delays in care, compromised patient experience and increased costs
- risk of failure to achieve ambulance Red 8 target
- maintenance of 24/7 A&E services at Weston Area Health Trust

3.102 The remaining 13 risks on the Corporate Risk Register were all scored as amber (rating of 12).

3.103 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.

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

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

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

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

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

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

3.109 As well as overseeing the anti-fraud, bribery and corruption arrangements in place within its providers, the CCG also needs to ensure its own counter fraud measures remain robust. Somerset CCG has well established counter fraud arrangements in order to help the organisation achieve the standards set out by NHS Protect. The CCG engages an Accredited Counter Fraud Specialist to implement an on-going programme of anti-fraud, bribery and corruption work across the whole organisation. During 2016/17 work has involved the delivery of an annual

work plan which follows NHS Protects strategy to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all 4 key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

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

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

3.112 The LCFS was requested to undertake a review of the high cost Continuing Healthcare (CHC) placements where the CCG is funding 'additional needs' payments for patient care. A number of recommendations were made by the LCFS following this case and have been addressed.

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

3.114 The Clinical Commissioning Group continues to set a challenging QIPP programme, which sees planned QIPP savings in excess of £19m within the 2016/17 financial plan. These QIPP schemes are vigorously monitored through the Programme Management Office to ensure key risks and issues are identified and decisions taken at the Leadership Team where required. Through the Sustainability and Transformational Planning meetings local leaders continue to discuss QIPP/CIP assumptions to ensure a robust peer challenge is in place across Somerset, but to also confirm clear assumptions are in place to ensure no double counting across organisations.

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

3.116 To support this, the Clinical Commissioning Group 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 fortnightly to review the position and has an active work programme which is being actioned through the Clinical Commissioning Group Leadership team.

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

The Better Care Fund

3.118 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 2016/17 through a signed agreement under Section 75 of the National Health Service Act 2006.

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

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

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

- plans are jointly agreed
- maintains the provision of social care services
- agreement for the delivery of selected 7-day services across health and social care to prevent unnecessary non-elective admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate
- better data sharing between health and social care, based on the NHS number

- ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional
- agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans
- agreement to invest in NHS commissioned out-of-hospital services which may include a wide range of services including social care
- agreement on a local target for Delayed Transfers of Care (DTOC)

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

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

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

- effectiveness of reablement - Reduce unplanned admissions and readmissions to hospital
- delayed transfers of care - Reduce hospital length of stay by enabling people, who no longer require acute medical intervention, to have a timely discharge from hospital
- admissions to residential and care homes - Reduce demand for domiciliary care and residential/nursing care
- patient/service user experience - Deliver improvement in an Individual's quality of life

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

- the day to day operation and management of the Pooled Fund
- ensuring that all expenditure from the Pooled Fund is in accordance with the provisions of the Section 75 Agreement and the relevant Scheme Specification
- maintaining an overview of all joint financial issues affecting the Partners in relation to the Services and the Pooled Fund
- ensuring that full and proper records for accounting purposes are kept in respect of the Pooled Fund
- ensuring action is taken to manage any projected under or overspends relating to the Pooled Fund in accordance with the Section 75 agreement
- reporting to the Joint Commissioning Board as required, the BCF Guidance and the relevant Scheme Specification

- preparing and submitting to the Joint Commissioning Board Quarterly reports and an annual return about the income and expenditure from the Pooled Fund together with such other information as may be required by the Partners and the Joint Commissioning Board to monitor the effectiveness of the Pooled Fund and to enable the Partners to complete their own financial accounts and returns. The Partners agree to provide all necessary information to the Pooled Fund Manager in time for the reporting requirements to be met. Detailed monitoring of expenditure was completed through the Joint Commissioning Board finance Sub Group
- preparing and submitting reports to the Health and Wellbeing Board as required by it which shall include the submission of copies of the Quarterly and Annual reports to the Joint Commissioning Board

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

Control Issues

3.125 In January 2017, a month 9 Governance Statement Report was submitted to NHS England. This return highlighted two areas 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
Failure to discharge statutory duty – financial control	The CCG's assurance rating will be amended at the end of 2016/17 to reflect the finance decline in year. The implications for the CCG are: • the appointment of System Turnaround Team working across the Somerset footprint, including the 3 Foundation Trusts and CCG • production of a financial recovery plan • the development of a Sustainability and Transformation Plan (STP) across the health economy including a trajectory to achieve financial recovery in the planning period to 2020/21 • a fortnightly Finance Group, chaired by the Chair of the Audit Committee, and attended by the Managing Director, Chair, 2 GPs, Chief Finance Officer and Practice Manager, with a rolling work programme focusing on Finance Recovery Plan delivery • Finance Recovery Plan presented to the Clinical Leadership meeting on a bi-weekly basis • control mechanisms put in place for travel and courses, off-site meetings, recruitment and all commitments >£1,000

	• system financial reporting, including agreeing forecast outturn position with local providers
Organisational performance	The CCG has put in controls for managing provider performance including a monthly Access and Performance Group meeting (APG) with both Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust, which includes regulator attendance. The CCG has performance recovery action plans from both providers, which are monitored through the APG for each area of underperformance. Somerset CCG applies contract performance notices where appropriate with all providers where the CCG is the lead commissioner (Taunton and 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 (where 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. Remedial Action Plans (RAPs) have been requested during 2016/17 on the following areas: • A&E 4 hours standard, aligned to the 5 nationally mandated improvement actions – T&S, YDH • RTT incompletes (all specialties) – T&S (including outcome of VIST review), YDH • 62 day Cancer – T&S, YDH • Diagnostics – T&S The RAPs remain under continued review with progress monitored; the CCG is in attendance at the number of internal Trust meetings (including the weekly RTT 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 CCG has also commissioned additional activity through the independent sector, and patients are offered this choice through the Referral Management Centre. The CCG is working with the system to identify areas for demand management opportunity, which include:

	• review of referral benchmarking for individual GP practices and federations • the introduction of a patient initiated follow up outpatient scheme • the introduction of two GP 999 cars

Counter Fraud Arrangements

3.126 The 2016/17 Annual Counter Fraud Work Plan was prepared in accordance with:

- the NHS Protect policy 'Tackling Crime against the NHS – a strategic approach' which details the 3 key principle areas of work that underpin both national and local anti-fraud activity

- the NHS Protect standards for commissioners – fraud, bribery and corruption, in order to ensure NHS funds and resources are safeguarded against those minded to commit fraud, bribery and corruption

3.127 The Counter Fraud work plan for 2016/17 was produced taking into account:

- discussions with the Chief Finance Officer and members of the Audit Committee
- the NHS Protect 29 specified standards
- 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

3.128 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.

3.129 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.

Review of Effectiveness

3.130 As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the

effectiveness of the system of internal control is informed by the work of the Internal Auditors and the executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the External Auditors in their management letter and other reports.

3.131 The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives have been reviewed and there are actions in place to mitigate risks and address gaps in controls. The format of the Assurance Framework has been developed during 2016/17 to build upon best practice and audit review and has further enhanced the effectiveness of the tool for the Governing Body.

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

3.133 The Audit Committee received the Head of Internal Audit's report on the Assurance Framework as part of the internal audit programme 2016/17. No significant issues or gaps in assurance were identified in the CCG risk management and assurance systems or processes within the audit. The findings of the audit concluded there was moderate assurance for both design and operational effectiveness. The Governing Body can take substantial assurance that the controls upon which the organisation relies to manage this area are suitably designed, consistently applied and effective.

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

- External and Internal Audit reports and action plans are submitted to the Audit Committee on a regular basis, with the minutes and action reported to the Governing Body
- reports made by the Local Counter Fraud and Security Management service on proactive investigations, suspected frauds or irregularities within the Trust or within the country which may have an impact upon the trust, again submitted to the Audit Committee on a regular basis, with the minutes and actions reported to the Governing Body
- developing and maintaining an Assurance Framework, with officers identifying key controls relied upon and an action list where risks remain
- active assessment and mitigation of risk which is monitored and reviewed by the Governance Committee through the Corporate Risk Register, with minutes reported to the Governing Body
- monitoring and investigating complaints - which are reported at the Governance Committee, with minutes and action plans reported to the Governing Body. Issues about risks and systems are actioned by appropriate lead officers

- monitoring issues arising from the Patient Advice and Liaison Service (PALS) and the impact these may have on systems and internal controls. Issues are reported regularly to the Governance Committee
- monitoring and investigating serious untoward incidents and reporting on the lessons learned and implementation of action plans
- monthly reporting of the financial position of the CCG to the Governing Body
- monthly reporting to the Governing Body and the Clinical Operations Group of the performance position against principal national and local targets
- weekly meetings of the Leadership Team to discuss performance and key requirements of the organisation, including risk management and internal controls
- the Governance Committee receives reports on progress against actions planned against identified risk across the organisation. It is the responsibility of all Directors to progress identified actions in accordance with the Risk Register and associated action plans

Head of Internal Audit Opinion

3.135 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 faced financial challenges and is reporting a forecast deficit of £3m.
- We noted that the CCG has performed well in implementing outstanding audit recommendations, with 28 out of 29 due by year end noted as complete. The remaining item is not yet due.
- The CCG has displayed strong contract management controls despite moving to a PbR environment for two main contracts in 2016/2017.
- Two limited assurance opinions has been awarded in the year, in relation to the IT strategy and safeguarding audits. Management have specifically requested reviews in these areas to strengthen controls.

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

Audit	**Director**	**Summary and Actions**
Key Financial Systems – General Ledger	Alison Henly Chief Finance Officer and Director of Performance	**Design**: substantial **Effectiveness**: substantial **Recommendations**: 3 low significance **Summary of report**: As part of our rotational review of the key financial systems, the Trust's controls surrounding the general ledger were reviewed. This included the access rights within the Oracle system as well as the management of key general ledger activities including journal processing and control account reconciliations. A review of the CCG's financial reporting was also undertaken ensuring this reconciles to the financial information within the general ledger. The review noted the following areas of good

		practice: • robust process in place for regularly monitoring access to the Oracle system. New accounts are only created following a formal verification process, including authorisation limits and defined responsibilities • journals and control account reconciliations were found to have been created accurately, in line with CCG policies and were approved within a timely manner • robust processes for reconciling the information contained within the CCG's finance reports to the Governing Body to that contained within the general ledger • feedback obtained from Non-Executive Directors indicated that they were very happy with the content and format of the finance report. Common feedback included the report being 'clear, concise and easy to understand' However, we also identified the following opportunities to enhance the controls in place around the general ledger: • no formalised process in place for reviewing the Oracle user responsibilities allocated to members of the finance team, to ensure they are reasonable. We identified that the finance team still have the ability to create users within Oracle despite this function being managed by SBS • the automated process (managed by SBS) for removing inactive users from the Oracle system within 90 days was not functioning. Our testing identified that there are six individuals who have not accessed the system within this timeframe but still have live access • there are small opportunities to enhance certain aspects of the finance report presented to the Governing Body to demonstrate compliance with best practice. This includes amending the presentation of some of the information included to allow easier consumption of key messages
Somerset Together – Most Capable Provider	Steven Foster Director of System Transformation	**Advisory Audit** **Scope of report:** At the request of the Governing Body, the CCG's Internal Auditors were asked to provide independent assurance on the Most Capable Provider Process –

		Capability Assessment 1 (CA1). To undertake this audit, the following activities were undertaken: • attended a Somerset Together briefing session • reviewed the CA1 guidance for evaluators • reviewed the submission criteria • attended the evaluator catch up call • reviewed the submission criteria from each co-ordinating provider • completed a shadow assessment for each co-ordinating provider • attended the moderation meeting • sought informal feedback from two individuals involved in the co-ordinating provider submission process **Outcome of Audit:** Overall, the CA1 process was undertaken in a fair and consistent way. There was a robust and considered process to determine the readiness of the co-ordinating providers using subject matter experts as part of the evaluation panel. To enhance the process for CA2, it was recommended that the CCG strengthen the engagement, earlier in the process, and include the opportunity for an interview or panel discussion to better understand the reality of the vision being portrayed.
Contract Management	Paul Goodwin Director of Commissioning Reform and Governance	**Design:** moderate **Effectiveness:** substantial **Recommendations:** 2 medium significance **Summary of Report:** The purpose of the audit was to undertake a review of the key provider contracts within the CCG to ensure that there are robust contract management and governance procedures in place. In particular, payment mechanisms were checked to ensure they are in line with the agreed terms and conditions of the contract. From our review, the following areas of good practice were noted, that the CCG should leverage in moving to the new Risk Share Agreement: • there is a robust process in place for contract performance monitoring and review. There are clear arrangements for regularly monitoring contracts and this is further supported by

		evidence of performance meetings and follow ups of agreed actions. This level of work in this area will support the reporting and performance principle of the new set up where the CCG needs to provide granularity on their position for other provider contracts, CHC, GP prescribing, and other contracts • formal minutes or actions logs are maintained for all contract review meetings held with the providers • there is an established Finance and Information Group (FIG) for each of the main NHS provider contracts. Their main role is to manage issues relating to finance, activity and other information relevant to the 2016/17 contracts. The group also ensures compliance with the requirements of the Information Schedule within the contract and understand data flows and developments for future information needs • a robust and sufficient forecasting method is used for contract monitoring and negotiation However, we also identified the following opportunities to enhance the controls in place around contract management: • there is no formal or documented process in place to demonstrate the CCG's approach to contract management • a contract database or register is not maintained
Conflicts of Interest	Paul Goodwin Director of Commissioning Reform and Governance	**Design:** moderate **Effectiveness:** moderate **Recommendations:** 5 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 2016) 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 comprehensive procedures in place to ensure that conflicts of interest are identified, declared and escalated to the appropriate register in a timely manner • the CCG is implementing a live register system for recording conflicts of interest which will provide employees with individuals logins such that they are able to input their declarations directly onto the system. This allows the CCG to monitor the registers in real time and removes the need for somebody to receive declarations and manually input them onto a register • there are procedures in place to ensure all individuals involved in the procurement process, both within the CCG and within bidding organisations, declare any conflicts of interest or sign off to declare that no conflicts exist • there is a defined procedure to follow when an individual identifies a breach in the conflicts of interest policy It should be noted that a national consultation exercise has been taking place on revised guidance regarding managing conflicts of interest which has delayed roll out of the promised training package and which the CCG was keen to take account of before undertaking further development work on the system for managing interests and gifts and hospitality. **Opportunities for enhancement** Recommendations have been raised against each of the areas of the assessment and summarised below: • there are areas of the CCG's conflicts of interest policies which are not compliant with statutory guidance set by NHS England. The CCG should review the conflicts of interest policy against the checklist set out in the 'Managing Conflicts of Interest: Revised Statutory Guidance for CCGs' document published by NHS England to ensure the CCG is fully compliant • there is currently no programme in place to provide staff with annual conflicts of interest training although the CCG provides guidance during induction and via general updates to staff. NHS England are in the process of producing a mandatory training tool which will

		then be used by the CCG to provide conflicts of interest training. However, this will not come into effect until 2017/18 and until this training tool is produced, the CCG is obligated to produce training materials and provide conflicts of interest training to staff during 2016/17 • the currently published registers of interest, gifts and hospitality and procurement decisions do not contain sufficient details and are therefore non-compliant with statutory guidance. For example, the published register of interests does not include the 'type' of interest being declared, the dates to which the interest relate and the actions that are being taken to mitigate the risk. The registers however will all be updated with the introduction of the electronic database and reporting tool being developed by the CCG. The registers should be updated to comply with statutory guidance and the updated registers should be published • the records kept to evidence that sufficient consideration is given to conflicts of interest during decision making processes are insufficient to ensure compliance with statutory guidance, however the processes do allow for detailed discussion to be recorded. For example, additional information is required to show the magnitude of a declared interest, how the interest is to be managed, and evidence that the interest was managed as indicated • the guidance on what procedures should be undertaken during the contract monitoring process could be strengthened to ensure conflicts of interest are identified and managed appropriately throughout the contract. The contract monitoring groups should, where appropriate, be holding more detailed discussions on conflicts of interest and how these are being managed and these discussions should be appropriately recorded within meeting minutes to evidence that conflicts are being considered • the conflicts of interest policy identified the process that should be taken when breaches are identified, however there should be clarity over what should be done when a breach in the conflicts of interest policy impacts upon a contract which the CCG has already entered into. CCG policy should be updated to ensure staff know what to do when such a breach occurs

Safeguarding	Sandra Corry Director of Quality and Safety	**Design:** limited **Effectiveness:** limited **Recommendations:** 3 High significance**,** 6 medium significance The purpose of the review was to provide assurance that appropriate arrangements are in place and operating effectively in relation to safeguarding children. The following aspects of the CCG's management of conflicts of interest were considered to be good practice: • A majority of the stakeholders audit engaged with during the review indicated that the CCG safeguarding children team offered either moderate or high levels of support to stakeholders for safeguarding children. • The CCG has published a number of policy and guidance documents designed to assist stakeholders carry out their obligations for safeguarding children. • The core of the safeguarding children team is relatively new to the CCG and are determined to ensure there are robust practices in place for safeguarding children. However, the audit identified a number of control weaknesses including: • The safeguarding children team does not have sufficient resources to meet its obligations or to meet the minimum requirements of published guidance. • discussions with staff indicated that there is currently no safeguarding strategy within the CCG. Without such a strategy there is a risk that the CCG is not taking a consistent and robust approach to safeguarding children, and opportunities for improving the CCG's safeguarding procedures may not be taken. • Audit testing found that Safeguarding policies and procedures are scattered around the CCG, with there being no central store of information where staff and/or members of the public are able to easily access the CCG's policies and procedures relating to safeguarding children and gain information on how the CCG carries out its responsibilities within this area. • A lack of information on safeguarding children and the CCG's role in safeguarding children was also identified as one of the main concerns by stakeholders who responded to the survey

		distributed as part of this review. • There is currently no data held with mandatory safeguarding children training for primary care surgeries. There is also a lack of clarity regarding the CCG's own performance in safeguarding children training, with no information made available during the course of the audit. Furthermore, the compliance rate for NHS providers also did not meet minimum expectations and there is incomplete data for level 3 compliance.
IT Strategy Alignment	Paul Goodwin Director of Commissioning Reform and Governance	**Design:** limited **Effectiveness:** moderate **Recommendations:** 2 High significance**,** 2 medium significance The purpose of the review was to provide assurance as to the alignment of the IT strategies across the county, ensuring that any challenges or conflicts are being identified, discussed and resolved as part of the creation of the Somerset Accountable Care System (ACS). Good practice was highlighted in the respect of a Digital Steering Group being established and an effective risk register is in place. However, the following areas of improvement were highlighted: • The objectives and benefits of the Somerset Digital Roadmap work streams have not been adequately defined nor are they measurable. • There are not adequate funding and budget management arrangements in place. The CCG does not fully accept the recommendations of the audit report and believe that to be successful, digital transformation must be clinically led with the benefits, and how these are measured and budgeted, being integral to the emerging service changes and new models of care rather than completed as a standalone work stream. The CCG has agreed an action plan to work in tandem with internal audit to take this forward.

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

CONCLUSION

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

Signed:

David Slack
Accountable Officer
Somerset Clinical Commissioning Group
Date: 25 May 2017

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 2017 are listed below grouped within their Commissioning Locality.

Bridgwater Bay Health

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

Central Mendip

- Oakhill Surgery
- Grove House Surgery
- Park Medical Practice

Chard, Crewkerne and Ilminster

- West One Surgery
- Summervale Surgery
- Essex House Medical Centre
- The Meadows Surgery (Ilminster)
- Springmead Surgery
- Tawstock Medical Centre
- Church View 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
- Yeovil Health Centre
- 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
- Porlock Medical Centre
- Irnham Lodge Surgery
- Harley House Surgery
- Exmoor Medical Centre
- Dunster Surgery

Annex 2 (Governance Statement)

Somerset CCG Governing Body Meetings 2016/17– Attendance Record									✓ = Present X = Apologies Given		
(V) = voting Member (NV) = non-voting Member	28 Apr 16	26 May 16	23 Jun 16	21 Jul 16	15 Sep 16	20 Oct 16	17 Nov 16	15 Dec 16	26 Jan 17	23 Feb 17	30 Mar 17
Dr Matthew Dolman (V) Chair*1	*1	*1	*1	*1	*1	*1	*1	*1	X*2		
Ann Anderson (NV) Director of Clinical and Collaborative Commissioning	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	✓	✓	X	✓	X	✓	✓
Sandra Corry (NV) Director of Quality and Patient Safety								✓	✓	✓	X
Lou Evans (V) Vice Chair and Non-Executive Director, Governance and Audit*3	✓*3	✓*3	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Ed Ford (V) Chair of the Governing Body*4	✓	✓	✓*3	✓*3	✓*3	✓*3	✓*3	✓*3	✓*4	X	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor									✓	✓	✓
Paul Goodwin (NV) Director of Commissioning Reform	✓	✓	X	✓	X	✓	X	✓	✓	X	✓
Dr Stephen Gardiner (V) Interim COG Chair (Jun-Dec 2016)				✓	✓	✓	✓	X*2			
Judith Goodchild (NV) Healthwatch Observer					✓	X	X	✓	X	✓	X
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Dr Will Harris (V) Chair of the Clinical Operations Group*5								✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer and Director of Performance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Sean O'Kelly (V) Non-Executive Director, Secondary Care Specialist Doctor	X	✓	X	✓	X	✓	✓	✓	X*2		
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	X	✓	✓	X	✓	✓	✓	✓	X	✓	X
Dr Iain Phillips (V) Governing Body GP	✓	X	X	X*2							
Peter Rowe (NV) PPG Lay Observer	✓	X	✓	X	X	X	✓	✓	X	✓	✓
Dr Geoff Sharp (V) Governing Body GP	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X
David Slack (V) Managing Director/Accountable Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Somerset CCG Governing Body Meetings 2016/17– Attendance Record											✓ = Present X = Apologies Given
(V) = voting Member (NV) = non-voting Member	28 Apr 16	26 May 16	23 Jun 16	21 Jul 16	15 Sep 16	20 Oct 16	17 Nov 16	15 Dec 16	26 Jan 17	23 Feb 17	30 Mar 17
Eilleen Tipper (V) Non-Executive Director, PPE	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lucy Watson (NV) Director of Quality, Safety and Governance	✓	✓	✓	✓	✓	X*2					
Dr Harry Yoxall (NV) Local Medical Committee (Observer)	✓	X	✓	X	X	X	X	✓	✓	✓	X

*1 Not present due to secondment as Senior Responsible Officer for the Sustainability and Transformation Plan (STP)
*2 Stepped down/retired from role or changed position
*3 Present in the role of CCG Interim Chair due to Dr Dolman's secondment as SRO for the STP
*4 Confirmed as Chair of the Somerset CCG with effect from January 2017
*5 Confirmed as Chair of the Clinical Operations Group with effect from January 2017

Somerset CCG COG Meetings
2016/17 – Attendance Record

✓ = Present
X = Apologies Given

(V) = voting Member (NV) = non-voting Member	6 April 2016	11 May 2016	8 June 2016	13 July 2016	7 Sept 2016	5 Oct 2016	2 Nov 2016	7 Dec 2016	1 Feb 2017	1 Mar 2017
Dr Ed Ford (V) COG Chair*1 and West Somerset Health Locality Delegate	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Will Harris (V) COG Chair*1 and West Mendip Locality Delegate	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Stephen Gardiner (V) COG Vice Chair* and Bridgwater Bay Health Locality Delegate	✓	✓	✓	✓	✓	✓	✓	✓		
Dr Alex Murray (V) Bridgwater Bay Health Locality Delegate									✓	✓
Dr Joey McHugh (V) COG Vice Chair* and North Sedgemoor Locality Delegate			X	✓	X	✓	X	✓	X	✓
Dr John Trepess (V) Taunton Deane Locality Delegate	✓	✓	✓	✓						
Dr Will Chandler (V) Taunton Deane Locality Delegate									✓	✓
Dr Rob Allen (V) East Mendip Locality Delegate	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Dr Kate Staveley (V) Chard, Crewkerne and Ilminster Locality Delegate			✓	✓	✓	✓	X	✓	✓	✓
Dr Iain Phillips (V) South Somerset Locality Delegate	✓	✓	✓							
Daniel Vincent (V) Interim South Somerset Locality Delegate									✓	✓
Dr Geoff Sharp (V) Central Mendip Locality Delegate	X	✓	✓	X	✓	✓	✓	✓	✓	✓
Trudi Mann (V) Practice Manager Delegate	✓*2	✓	✓	✓	✓	✓	✓*2	✓	✓	✓*2
David Slack (V) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer, Director of Performance	X	X	✓	✓	✓	✓	✓	✓	✓	✓

(V) = voting Member (NV) = non-voting Member	6 April 2016	11 May 2016	8 June 2016	13 July 2016	7 Sept 2016	5 Oct 2016	2 Nov 2016	7 Dec 2016	1 Feb 2017	1 Mar 2017
Lucy Watson (V) Director of Quality, Safety and Governance	✓	✓	✓	✓	✓	✓	✓ (DR)			
Sandra Corry (V) Director of Quality, and Safety								✓	✓	X
Ann Anderson (V) Director of Clinical and Collaborative Commissioning	✓	X	✓	✓	✓	✓	✓	X	✓	✓
Paul Goodwin (V) Director of Commissioning Reform and Governance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Chandler (V) Director of Social Services Somerset County Council	✓	X	X	X	X	X	X	X	X	X
Dr Nick Bray / Dr Karen Sylvester (NV) GP & LMC Representative	✓	✓	✓	X	✓	✓	X	✓	X	Y
Peter Hillman (NV) Lay Member	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Sue Glanfield / Andrew Hill (NV) Heads of Department	✓	✓	✓	✓						
Tracey Tilsley (NV) Head of Business and Strategy					✓	✓	✓	✓	✓	✓

Initials in brackets indicate deputising arrangements as follows:
DR – Debbie Rigby attended as Interim Director for Lucy Watson following her retirement

*1 Dr Ed Ford and Dr Stephen Gardiner were COG Chair and Vice Chair until December 2016 after which Dr Will Harris and Dr Joey McHugh were appointed to those roles
*2 Practice Manager delegate represented by a deputy at these meetings

Somerset CCG Audit Committee Meetings 2016/17 – Attendance Record

✓ = Present
X = Apologies Given

Name	**Member (M)/ In Attendance (A)**	**18 May 2016**	**20 July 2016**	**21 Sept 2016**	**14 Dec 2016**	**15 Feb 2017**
Lou Evans Audit Committee Chair	M	✓	✓	✓	✓	✓
David Bell Non-Executive Director	M	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark Registered Nurse	M	✓	X	✓	✓	✓
Dr Geoff Sharp GP Member	M	✓	X	✓	✓	X
Eilleen Tipper Non-Executive Director	M	✓	✓	✓	✓	✓
Alison Henly Chief Finance Officer and Director of Performance	A	✓	✓	✓	✓	✓

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

Somerset CCG Governance Committee Meetings 2016/17 – Attendance Record
Given

✓ = Present
X = Apologies

(M) Committee member (A) In attendance	4 May 2016	27 Jul 2016	26 Oct 2016	8 Feb 2017
Dr Ed Ford (M) Chair and GP Governing Body Member	✓	✓	✓	✓
Ann Anderson (M) Director of Clinical Commissioning and Collaborative Commissioning	X (SG)	✓	✓	✓
Lou Evans (M) Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (M) Non-Executive Director, Registered Nurse	✓	X	✓	✓
Dr Will Harris (M) Chair of the Clinical Operations Group and GP Governing Body Member				✓
Alison Henly (M) Chief Finance Officer and Director of Performance	X (AR)	✓	X (DH)	✓
Dr Sean O'Kelly (M) Non-Executive Director, Secondary Care Specialist Doctor	X	X	X	
Dr Basil Fozard (M) Non-Executive Director, Secondary Care Specialist Doctor				✓
Dr Iain Phillips (M) GP	✓			
Dr Stephen Gardiner (M) GP			✓	
Eilleen Tipper (M) Non-Executive Director, PPE	✓	✓	✓	✓
Lucy Watson (M) Director of Quality, Safety and Governance	✓	✓	✓	
Paul Goodwin (M) Director of Commissioning Reform and Governance	✓	X	✓	✓
Karen Taylor (A) Head of Patient Safety and Governance	X	✓	✓	✓
Peter Osborne (A) Corporate Governance Manager	✓	✓	✓	✓

Initials in brackets indicate deputising arrangements as follows:
SG – Sue Glanfield for Ann Anderson
AR – Alison Rowswell for Alison Henly
DH – Debbie Hillier for Alison Henly

Somerset CCG Remuneration Committee Meetings 2016/17
Attendance Record

✓ = Present X = Apologies Given V = voting NV = non-voting	18.05.16	23.0616	15.09.16	15.12.16	26.01.17	23.02.17
Lou Evans (V) Remuneration Committee Chair	✓*[1]	✓	✓	✓	✓	✓
Eilleen Tipper (V) Remuneration Committee Vice Chair	✓*[2]	✓	✓	✓	✓	✓
David Bell (V) Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	x	✓
Dr Jayne Chidgey-Clark (V) Registered Nurse	✓	✓	✓	✓	x	✓
David Slack (NV) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	✓	✓	✓	✓	x	✓
Basil Fozard (V) Secondary Care Doctor	N/A	N/A	N/A	N/A	✓	✓

1. *[1] The Remuneration Committee determined that Lou Evans should not chair the Remuneration or Audit Committees during his period as Interim Chair of the CCG. Mr Evans therefore attended the Remuneration Committee meeting on 18 May 2016 in an observer capacity.
2. *[2] Acting Chair for Meeting held on 18 May 2016

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
2016/17 – Attendance Record X = Apologies Given

(M) Committee member (A) In attendance	Job Title	Committee Role (e.g. Executive, Lay, GP, etc)	16 Jun 16	8 Sept 16	8 Dec 18	16 Mar 17
David Bell (M)	Non-Executive Director, Chair of the Somerset Primary Care Joint Committee – Somerset CCG	Chair Non-Exec	✓	✓	✓	✓
Lou Evans (M)	Vice-Chair, Non-Executive Director, Governance and Audit – Somerset CCG	Vice Chair Non-Exec	✓	✓	✓	X
Ann Anderson (M)	Director of Clinical Commissioning Development– Somerset CCG	CCG	✓	✓	X	✓
Alison Henly (M)	Chief Finance Officer and Director of Performance – Somerset CCG	CCG	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (M)	Non-Executive Director, Registered Nurse – Somerset CCG	Non-Exec	X	X	X	X
Linda Prosser (M)	Director of Commissioning, NHS England	NHSE	✓	✓	✓	X
Eileen Tipper (M)	Non-Executive Director, PPE – Somerset CCG	Non-Exec	✓	✓	✓	✓
Lucy Watson (M)	Director of Quality, Safety and Governance – Somerset CCG	CCG	✓	X		
Sandra Corry (M)	Director of Quality and Safety– Somerset CCG	CCG			✓	X
Marina Muirhead/ Laila Pennington (M)	Head of Primary Care, NHS England	NHS E	X	X	✓	✓
Louise Woolway (M)	Public Health Consultant, Somerset County Council – Somerset CCG	SCC	X	✓	X	✓
Dr Sean O'Kelly (M)	Non-Executive Director, Secondary Care Specialist Doctor, Somerset CCG	Non-Exec	✓	X	X	
Dr Basil Fozard (M)	Non-Executive Director, Secondary Care Specialist Doctor, Somerset CCG	Non-Exec				✓
Dr Will Harris (M)	Chair of COG – Somerset CCG	GP		✓	✓	X
Clive Coleman (M)	Finance, NHS England	NHS Executive	X	✓	✓	X
Dr Chris Campbell (M)	External GP Member	External GP	✓	✓	X	✓
Martin Davidson	PPG Chairs Representative,	PPG Chair Rep	✓	X	✓	✓

(M) Committee member (A) In attendance	Job Title	Committee Role (e.g. Executive, Lay, GP, etc)	16 Jun 16	8 Sept 16	8 Dec 18	16 Mar 17
(M)	Somerset CCG					
Dr Nick Bray (M)	Chairman, Somerset Local Medical Committee	LMC	✓	✓	✓	✓
Dr Kate Staveley (M)	COG GP Representative	GP		✓	X	✓
Tariq White (M)	Assistant Director of Transformation and Outcomes, NHS England South (South West)	NHS E	✓	✓	X	X
Anne Woodford / Jacqueline Briggs (M)	Healthwatch Representative	Healthwatch	X	X	X	X
Tanya Whittle (M)	Associate Director: Community Services and Primary Care, Somerset CCG	CCG	✓	✓	✓	✓
Michael Bainbridge (A)	Head of Primary Care	CCG	✓	✓	✓	✓

Remuneration and Staff Report

Remuneration Report

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

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

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

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

Salary Entitlements of Senior Managers

		Total 2016/17						Total 2015/16					
		Salary	Expense payment (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total	Salary	Expense payments (taxable)	Performance Pay and Bonuses	Long Term Performance Pay and Bonuses	All Pension Related Benefits	Total
Name	Title	(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £00)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£'00	£'000	£'000	£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'000
David Slack	Managing Director/ Accountable Officer	125-130	0	0	0	55-57.5	180-185	120-125	0	0	0	5-7.5	125-130
Alison Henly	Chief Finance Officer and Director of Performance	100-105	56	0	0	30-32.5	140-145	100-105	44	0	0	27.5-30	135-140
Paul Goodwin	Director of Commissioning and Governance	105-110	40	0	0	10-12.5	125-130	100-105	32	0	0	0	100-105
Lucy Watson	Director of Quality, Safety and Governance	60-65	0	0	0	30-32.5	90-95	100-105	0	0	0	17.5-20	115-120
Ann Anderson	Director of Clinical and Collaborative Commissioning	100-105	39	0	0	45-47.5	150-155	95-100	42	0	0	17.5-20	115-120
Edward Ford	Chair	60-65	0	0	0	15-17.5	75-80	50-55	0	0	0	12.5-15	65-70
Steven Foster	Director of System Transformation	90-95	0	0	0	0	90-95	15-20	0	0	0	2.5-5	20-25

Sandra Corry	Director of Quality, Safety and Engagement	30-35	0	0	0	80-82.5	110-115	0	0	0	0	0	0
Geoff Sharp	GP	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
Will Harris	COG Chair	15-20	0	0	0	87.5-90	105-110	0	0	0	0	0	0
Stephen Gardiner	COG Chair	25-30	0	0	0	7.5-10	30-35	0	0	0	0	0	0
David Bell	Non Exec Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Iain Phillips	GP	5-10	0	0	0	72.5-75	80-85	35-40	0	0	0	0-2.5	40-45
Lou Evans	Lay Member (Vice-Chair)	35-40	0	0	0	0	35-40	15-20	0	0	0	0	15-20
Eileen Tipper	Lay Member	10-15	0	0	0	0	10-15	10-15	0	0	0	0	10-15
Sean O'Kelly	Specialist Doctor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Basil Fozard	Secondary Care Doctor	0-5	0	0	0	0	0-5	0	0	0	0	0	0
Jayne Chidgey-Clark	Registered Nurse	10-15	0	0	0	0	10-15	0	0	0	0	0	0
Deborah Rigby	Interim Director of Quality and Safety	10-15	0	0	0	27.5-30	35-40	0	0	0	0	0	0

Officer Holder Changes:

Lucy Watson retired from the post of Director of Quality, Safety and Governance in October 2016
Ann Anderson retired from the post of Director of Clinical and Collaborative Commissioning in March 2017
Steven Foster left the post of Director of System Transformation in January 2017.
Dr Edward Ford was seconded to the post of Interim Chair from June 2016 and was appointed as Chair in January 2017.
Dr Geoff Sharp left the post of GP in March 2017
Dr Iain Phillips left his post of GP in June 2016.
Lou Evans was seconded to the post of Interim Chair from April 2016 until May 2016.
Eileen Tipper left the post of Lay Member in March 2017.
Dr Sean O'Kelly left the post of Specialist Doctor in December 2016.
Sandra Corry was appointed to the post of Director of Quality, Safety and Governance in November 2016
Deborah Rigby was seconded to the post of Interim Director of Quality, Safety and Governance in October 2016 until December 2016
Dr Stephen Gardiner was appointed to the post of Interim COG Chair in June 2016 and left the post of Interim COG Chair in December 2016
Dr Will Harris was appointed to the post of COG Chair in January 2017

Jayne Chidgey-Clark was appointed to the post of Registered Nurse in April 2016
Basil Fozard was appointed to the post of Secondary Care Doctor in January 2017

In addition the following individuals were seconded to the Sustainability Transformation Plan and these roles are not reflected in the above table:
Dr Matthew Dolman was seconded to the post of Senior Responsible Officer of the Somerset System Transformation Plan from 1st April 2016 and resigned from the post of Chair in December 2016.
Lou Evans was appointed to the role of Interim Chair of the Sustainability Transformation Plan for the period of xxx 2016 to xxx 2016

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 2016/17.

Senior Manager Pension Benefits

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

3.144 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 2017

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 2017 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2017 (bands of £5,000)	Cash equivalent transfer value at 1 April 2016	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2017	Employer's contribution to stakeholder pension
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Slack	Managing Director	2.5-5	7.5-10	40-45	125-130	784	88	872	0
Alison Henly	Chief Finance Officer and Director of Performance	0-2.5	0-2.5	30-35	85-90	465	36	501	0
Paul Goodwin	Director of Commissioning and Governance	0-2.5	2.5-5	40-45	125-130	743	42	785	0
Lucy Watson	Director of Quality, Safety and Governance	0-2.5	5-7.5	30-35	95-100	718	0	0	0
Ann Anderson	Director of Clinical and Collaborative Commissioning	2.5-5	7.5-10	25-30	80-85	565	0	0	0
Steven Foster	Director of System Transformation	0	0	0	0	4	0	0	0
Sandra Corry	Director of Quality, Safety and Engagement	0-2.5	2.5-5	30-35	95-100	598	20	655	0
Edward Ford	Chair	0-2.5	0	0-5	0	9	11	20	0
Will Harris	COG Chair	0-2.5	2.5-5	5-10	20-25	59	12	107	0
Stephen Gardiner	COG Chair	0-2.5	0-2.5	5-10	25-30	184	9	199	0
Iain Phillips	GP	0-2.5	0-2.5	20-25	65-70	363	22	451	0
Deborah Rigby	Interim Director of Quality and Safety	0-2.5	0-2.5	25-30	75-80	515	6	561	0

Notes:

1. Lay members do not receive pensionable remuneration.

2. Pensionable contributions may include more than just those from CCG employment. Where a GP is under a contract of service with the CCG and pays pension contributions then they are classed as 'NHS staff (Officer)' for pension purposes. The figures provided by NHS Pensions cover only the 'Officer' element of the GP's pension entitlement.

3. Dr Geoff Sharp is in receipt of NHS Pension

Cash equivalent transfer values

3.145 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.

3.146 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.

3.147 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

3.148 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.

Compensation and Terms of Office

3.149 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 directors

3.150 The Clinical Commissioning Group has made no payments to past directors during 2016/17.

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

3.152 The banded remuneration of the highest paid member of the Governing Body in Somerset CCG in the financial year 2016/17 was £127,500 (2015/16 £122,500). This was 3.80 times (2015/16 3.51 times) the median remuneration of the workforce, which was £33,560(2015/16 £34,876).

3.153 In 2016/17, zero employees received remuneration in excess of the highest paid member of the Governing Body. Remuneration ranged from £13,099 to £127,500 (2015/16 £11,808 to £122,500).

3.154 There was one exit package paid in 2016/17 with a total cost of £11,221. Details of these packages are within Note 4 of the Annual Accounts.

3.155 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.

3.156 The remuneration report and notes on pages xxx-xxx 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 2016 to 31 March 2017.
Cash Equivalent Transfer Value (CETV)	A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
Employer's contribution to stakeholder pension	The amount that the Clinical Commissioning Group has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related	The amount by which the lump sum to which an individual will

to real increase in pension	be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2017	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 2017
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 2017	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 2017

Remuneration of the Managing Director and Directors

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

3.158 The membership and attendance at the Somerset CCG Remuneration Committee during 2016/17 is set out below:

Somerset CCG Remuneration Committee Meetings 2016/17
Attendance Record

✓ = Present X = Apologies Given V = voting NV = non-voting	18.05.16	23.0616	15.09.16	15.12.16	26.01.17	23.02.17
Lou Evans (V) Remuneration Committee Chair	✓*[1]	✓	✓	✓	✓	✓
Eilleen Tipper (V) Remuneration Committee Vice Chair	✓*[2]	✓	✓	✓	✓	✓
David Bell (V) Chair of the Joint Committee for Commissioning Primary Care	✓	✓	✓	✓	x	✓
Dr Jayne Chidgey-Clark (V) Registered Nurse	✓	✓	✓	✓	x	✓
David Slack (NV) Managing Director/ Accountable Officer	✓	✓	✓	✓	✓	✓
Marianne King (NV) Head of HR	✓	✓	✓	✓	x	✓
Basil Fozard (V) Secondary Care Doctor	N/A	N/A	N/A	N/A	✓	✓

*[1] The Remuneration Committee determined that Lou Evans should not chair the Remuneration or Audit Committees during his period as Interim Chair of the CCG. Mr Evans therefore attended the Remuneration Committee meeting on 18 May 2016 in an observer capacity.

*[2] Acting Chair for Meeting held on 18 May 2016

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 2016/17 and future years

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

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

Policy on Contracts

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

Staff Report

Number of senior managers

The number of very senior managers is set out below in paragraph 3.165.

Staff numbers and costs

3.162 The Somerset CCG's total staff costs for the year ended 31 March 2017 are summarised in the following table:

Employee benefits	2016-17 Permanent Employees	Admin Other	Total	Permanent Employees	Programme Other	Total	Permanent Employees	Total Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	5,374	87	**5,461**	605	1	**606**	5,979	88	**6,067**
Social security costs	563	0	**563**	68	0	**68**	631	0	**631**
Employer Contributions to NHS Pension scheme	674	0	**674**	71	-	**71**	745	0	**745**
Other pension costs	-	-	**-**	-	-	**-**	-	-	**-**
Other post-employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Other employment benefits	-	-	**-**	-	-	**-**	-	-	**-**
Termination benefits	11	-	**11**	-	-	**-**	11	-	**11**
Gross employee benefits expenditure	6,622	87	**6,710**	743	1	**744**	7,366	88	**7,454**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	**-**	-	-	**-**	-	-	**-**
Total - Net admin employee benefits including capitalised costs	6,622	87	**6,710**	743	1	**744**	7,366	88	**7,454**
Less: Employee costs capitalised	-	-	**-**	-	-	**-**	-	-	**-**
Net employee benefits excluding capitalised costs	6,622	87	**6,710**	743	1	**744**	7,366	88	**7,454**

Average Number of Persons Employed

3.163 The average number of Clinical Commissioning Group staff employed by staff grouping are as follows:

4.2 Average number of people employed			2016/17	2015/16
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	5	0	5	3
Administration and estates	110	4	114	90
Nursing, midwifery and health visiting staff	15	0	15	6
Scientific, therapeutic and technical staff	3	0	3	7
Total	**133**	**4**	**137**	105
Of the above:				
Number of whole time equivalent people engaged on capital projects	**-**	-	-	-

3.164 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 administration and estates staff relates to the in housing of finance and individual funding requests functions from the South Central and West Commissioning Support Unit towards the end of 2015/16.

Staff composition

3.165 The breakdown of the gender profile for the CCG as at the end of March 2017 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	64%	36%	11 (one vacancy)
Membership Body Clinical Operations Group Voting Members	56%	44%	16
Very Senior Managers	50%	50%	4
All substantive CCG Staff	23%	77%	169

Sickness absence data

Staff sickness absence and ill health retirements	2016-17 Number	2015-16 Number
Total Days Lost	**340**	420
Total Staff Years	**126**	93
Average working Days Lost	**2.7**	4.5

3.166 2016/17 staff sickness values is based on a 12 month period covering the calendar year of 2016. 2015/16 staff sickness values are based on a 12 month period covering the calendar year of 2015. Sickness values for 2016/17 are not currently available.

3.167 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

3.168 The Clinical Commissioning Group has applied the Health Problems and Disability in Employment policy in 2016/17.

Expenditure on consultancy

3.169 The Clinical Commissioning Group consultancy expenditure in 2016/17 was £594,000 (2015/16 £1,232,000), as per note 5 in the annual accounts.

Off-payroll engagements

3.170 For all off-payroll engagements as at 31 March 2017, for more than £220 per day and that last longer than six months:

Off-payroll engagements longer than 6 months

	Number
Number of existing engagements as of 31 March 2017	12
Of which, the number that have existed:	
for less than one year at the time of reporting	7
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	2
for between 3 and 4 years at the time of reporting	3
for 4 or more years at the time of reporting	0

3.171 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.

3.172 For all new off-payroll engagements between 1 April 2016 and 31 March 2017, for more than £220 per day and that last longer than six months:

New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017	7
Number of new engagements which include contractual clauses giving NHS Somerset CCG the right to request assurance in relation to income tax and National Insurance obligations	7
Number for whom assurance has been requested	7
Of which:	
assurance has been received	6
assurance has not been received	1
engagements terminated as a result of assurance not being received.	0

3.173 For any off-payroll engagements of Board members and / or senior officials with significant financial responsibility, between 1 April 2016 and 31 March 2017.

Off-payroll engagements / senior official engagements

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.	17

Exit packages, including special (non-contractual) payments

Exit Packages

Exit package cost band (inc. any special payment element	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s	WHOLE NUMBERS ONLY	£s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000 - £25,000	0	0	1	11,221	1	11,221	0	0
£25,001 - £50,000	0	0	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0	0	0
£150,001 – £200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	0	0	1	11,221	1	11,221	0	0

Redundancy and other departure cost have been paid in accordance with the provisions of the Clinical Commissioning Group terms and contract of employment, PILON (payment in lieu of notice) clause. Exit costs in this note are accounted for in full in the year of departure. Where the NHS Somerset CCG has agreed early retirements, the additional costs are met by the NHS Somerset CCG and not by the NHS Pensions Scheme. Ill-health retirement costs are met by the NHS Pensions Scheme and are not included in the table.

Analysis of Other Departures

	Agreements	Total Value of agreements
	Number	**£000s**
Voluntary redundancies including early retirement contractual costs	**0**	**0**
Mutually agreed resignations (MARS) contractual costs	**0**	**0**
Early retirements in the efficiency of the service contractual costs	**0**	**0**
Contractual payments in lieu of notice	**1**	**11**
Exit payments following Employment Tribunals or court orders	**0**	**0**
Non-contractual payments requiring HMT approval**	**0**	**0**
TOTAL	**1**	**11**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 4 which will be the number of individuals.

Signed:

David Slack

Accountable Officer

Somerset Clinical Commissioning Group

Date: 25 May 2017

Appendix One

NHS Somerset Clinical Commissioning Group - Annual Accounts 2016-17

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

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Income from sale of goods and services	2	(2,000)	(2,231)
Other operating income	2	(1,058)	(1,390)
Total operating income		**(3,058)**	**(3,621)**
Staff costs	4	7,454	6,152
Purchase of goods and services	5	721,065	695,347
Depreciation and impairment charges	5	78	37
Provision expense	5	358	708
Other Operating Expenditure	5	603	557
Total operating expenditure		**729,558**	**702,801**
Net Operating Expenditure		**726,500**	**699,180**
Finance income			
Finance expense	10	0	0
Net expenditure for the year		**726,500**	**699,180**
Net Gain/(Loss) on Transfer by Absorption		0	0
Total Net Expenditure for the year		**726,500**	**699,180**
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			
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 2017		**726,500**	**699,180**

The notes on pages 5 to 36 form part of this statement

Statement of Financial Position as at 31 March 2017

	Note	2016-17 £'000	2015-16 £'000
Non-current assets:			
Property, plant and equipment	13	370	394
Intangible assets	14	13	17
Investment property	15	0	0
Trade and other receivables	17	0	0
Other financial assets	18	0	0
Total non-current assets		383	411
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	7,684	5,487
Other financial assets	18	0	0
Other current assets	19	0	0
Cash and cash equivalents	20	49	50
Total current assets		**7,735**	5,539
Non-current assets held for sale	21	0	0
Total current assets		**7,735**	5,539
Total assets		**8,118**	5,950
Current liabilities			
Trade and other payables	23	(37,178)	(29,997)
Other financial liabilities	24	0	0
Other liabilities	25	0	0
Borrowings	26	0	0
Provisions	30	(779)	(910)
Total current liabilities		**(37,957)**	(30,907)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(29,839)**	(24,957)
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		**(29,839)**	(24,957)
Financed by Taxpayers' Equity			
General fund		(29,839)	(24,957)
Revaluation reserve		0	0
Other reserves		0	0
Charitable Reserves		0	0
Total taxpayers' equity:		**(29,839)**	(24,957)

The notes on pages 5 to 36 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on [date] and signed on its behalf by:

David Slack
Accountable Officer
NHS Somerset Clinical Commissioning Group

Statement of Changes In Taxpayers Equity for the year ended 31 March 2017

	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 between reserves in respect of assets transferred from closed NHS bodies	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 expenditure 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)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2015-16				
Balance at 01 April 2015	**(24,826)**	**0**	**0**	**(24,826)**
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 2016	**(24,826)**	**0**	**0**	**(24,826)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2015-16				
Net operating costs for the financial year	(699,180)			(699,180)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(699,180)**	**0**	**0**	**(699,180)**
Net funding	699,049	0	0	699,049
Balance at 31 March 2016	**(24,957)**	**0**	**0**	**(24,957)**

The notes on pages 5 to 36 form part of this statement

Statement of Cash Flows for the year ended
31 March 2017

	Note	**2016-17 £'000**	2015-16 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(726,500)	(699,180)
Depreciation and amortisation	5	78	37
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	(2,197)	(164)
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	7,433	(130)
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(489)	(320)
Increase/(decrease) in provisions	30	358	708
Net Cash Inflow (Outflow) from Operating Activities		**(721,317)**	(699,049)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(302)	0
(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		**(302)**	0
Net Cash Inflow (Outflow) before Financing		**(721,619)**	(699,049)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		721,618	699,049
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		**721,618**	699,049
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(1)**	0
Cash & Cash Equivalents at the Beginning of the Financial Year		**50**	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		**49**	50

The notes on pages 5 to 36 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. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2016-17 issued by the Department of Health. 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 (despite the issue of a report to the Secretary of State for Health under Section 30 of the Local Audit and Accountability Act 2014).
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.5 Charitable Funds

Somerset Clinical Commissioning Group does not have any Charitable Funds

1.6 Pooled Budgets

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

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- valuation assumptions for property, plant and equipment – note 13
- Provisions recognised as at 31 March 2017 – note 30
- Income and Expenditure Accruals – notes 17 and 23

Notes to the financial statements

1.8 **Revenue**

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

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

1.9 **Employee Benefits**

1.9.1 **Short-term Employee Benefits**

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

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

1.9.2 **Retirement Benefit Costs**

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

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

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

1.10 **Other Expenses**

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

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

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

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

1.11.2 **Valuation**

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

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

1.12 **Intangible Assets**

1.12.1 **Recognition**

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

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

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

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

1.12.2 **Measurement**

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

Notes to the financial statements

1.13 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

1.14 **Donated Assets**

Somerset Clinical Commissioning Group does not have any donated assets.

1.15 **Government Grants**

Somerset Clinical Commissioning Group does not have any government grants.

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

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

1.17 **Leases**

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

1.17.1 **The Clinical Commissioning Group as Lessee**

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

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

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

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

1.17.2 **The Clinical Commissioning Group as Lessor**

The Clinical Commissioning Group does not have any lessor arrangements.

1.18 **Private Finance Initiative Transactions**

Somerset Clinical Commissioning Group does not hold 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 2.70% (previously: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1.95% (previously: minus 1.%)
- Timing of cash flows (over 10 years): Minus 0.80% (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.

Somerset Clinical Commissioning Group is moving towards being a Strategic Commissioning organisation, with the introduction of an Accountable Care System underpinned by an Outcomes Based Contractual model. The Clinical Commissioning Group is developing a formal plan for this process through an NHS England Assurance process and as part of this will produce a formal restructuring plan. At this stage it is not expected that a restructuring provision will be required and this will be tested through the Assurance process during 2017/18.

Notes to the financial statements

1.22 **Clinical Negligence Costs**

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

1.23 **Non-clinical Risk Pooling**

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

1.24 **Continuing healthcare risk pooling**

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

1.25 **Carbon Reduction Commitment Scheme**

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

1.26 **Contingencies**

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

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.

In the year ending 31 March 2017 there were no assets carried at fair value.

1.28 **Financial Liabilities**

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

In the year ended 31 March 2017, there were no financial liabilities held at fair value.

1.29 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.30 **Foreign Currencies**

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

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.33 **Subsidiaries**

The Clinical Commissioning Group does not have any subsidiaries.

1.34 **Associates**

The Clinical Commissioning Group does not have any associates.

1.35 **Joint Ventures**

The Clinical Commissioning Group does not have any joint ventures.

1.36 **Joint Operations**

The Clinical Commissioning Group does not have any joint operations.

1.37 **Research & Development**

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

Notes to the financial statements

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2016-17, all of which are subject to consultation:

- 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)

The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year.

2 Other Operating Revenue

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
Recoveries in respect of employee benefits	0	0	0	0
Patient transport services	0	0	0	0
Prescription fees and charges	0	0	0	0
Dental fees and charges	0	0	0	0
Education, training and research	11	11	0	160
Charitable and other contributions to revenue expenditure: NHS	0	0	0	0
Charitable and other contributions to revenue expenditure: non-NHS	0	0	0	0
Receipt of donations for capital acquisitions: NHS Charity	0	0	0	0
Receipt of Government grants for capital acquisitions	0	0	0	0
Non-patient care services to other bodies	1,989	160	1,829	2,071
Continuing Health Care risk pool contributions	0	0	0	0
Income generation	0	0	0	0
Rental revenue from finance leases	0	0	0	0
Rental revenue from operating leases	0	0	0	0
Other revenue	1,058	67	991	1,390
Total other operating revenue	**3,058**	**238**	**2,820**	**3,621**

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

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000
From rendering of services	3,058	238	2,820	3,621
From sale of goods	0	0	0	0
Total	**3,058**	**238**	**2,820**	**3,621**

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 2016-17 Total

	Total £'000	Permanent Employees £'000	Other £'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
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**

4.1.1 Employee benefits 2015-16 Total

	Total £'000	Permanent Employees £'000	Other £'000
Employee Benefits			
Salaries and wages	5,117	4,790	327
Social security costs	416	410	6
Employer Contributions to NHS Pension scheme	584	576	8
Other pension costs	0	0	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	35	35	0
Gross employee benefits expenditure	**6,152**	**5,811**	**341**
Less recoveries in respect of employee benefits (note 4.1.2)	0	0	0
Total - Net admin employee benefits including capitalised costs	**6,152**	**5,811**	**341**
Less: Employee costs capitalised	0	0	0
Net employee benefits excluding capitalised costs	**6,152**	**5,811**	**341**

4.1.2 Recoveries in respect of employee benefits

	2016-17 Total £'000	2016-17 Permanent Employees £'000	2016-17 Other £'000	2015-16 Total £'000
Employee Benefits - Revenue				
Salaries and wages	0	0	0	0
Social security costs	0	0	0	0
Employer contributions to the NHS Pension Scheme	0	0	0	0
Other pension costs	0	0	0	0
Other post-employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	0	0	0	0
Total recoveries in respect of employee benefits	**0**	**0**	**0**	**0**

4.2 Average number of people employed

	2016-17 Total Number	2016-17 Permanently employed Number	2016-17 Other Number	2015-16 Total Number
Total	**137**	**133**	**4**	**105**
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

	2016-17 Number	2015-16 Number
Total Days Lost	340	420
Total Staff Years	126	93
Average working Days Lost	2.7	4.5

	2016-17 Number	2015-16 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 2017.

4.4 Exit packages agreed in the financial year

	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**

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

	2016-17 Departures where special payments have been made		2015-16 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

	2016-17 Other agreed departures		2015-16 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	1	11,221	3	34,672
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	**1**	**11,221**	**3**	**34,672**

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

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

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

4.5 Pension costs

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

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

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

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2012 and covered the period from 1 April 2008 to that date. Details can be found on the pension scheme website at **www.nhsbsa.nhs.uk/pensions**.

For 2016-17, employers' contributions of £754,234 were payable to the NHS Pensions Scheme (2015-16: £602,407) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9 June 2014. These costs are included in the NHS pension line of note 4.1.1.

5. Operating expenses

	2016-17 Total £'000	2016-17 Admin £'000	2016-17 Programme £'000	2015-16 Total £'000	Notes
Gross employee benefits					
Employee benefits excluding governing body members	6,777	6,173	604	5,493	
Executive governing body members	677	537	140	659	
Total gross employee benefits	**7,454**	**6,710**	**744**	**6,152**	
Other costs					
Services from other CCGs and NHS England	3,445	2,655	790	4,821	
Services from foundation trusts	471,385	19	471,366	456,636	
Services from other NHS trusts	25,020	15	25,005	23,337	
Services from other WGA bodies	24	0	24	3	
Purchase of healthcare from non-NHS bodies	126,944	0	126,944	117,507	1
Chair and Non Executive Members	252	252	0	281	
Supplies and services – clinical	0	0	0	0	
Supplies and services – general	2,481	120	2,361	1,222	
Consultancy services	594	240	354	1,232	
Establishment	242	187	55	631	
Transport	2,256	14	2,242	1,997	
Premises	877	680	197	766	
Impairments and reversals of receivables	0	0	0	0	
Inventories written down and consumed	0	0	0	0	
Depreciation	74	74	0	34	
Amortisation	4	4	0	3	
Impairments and reversals of property, plant and equipment	0	0	0	0	
Impairments and reversals of intangible assets	0	0	0	0	
Impairments and reversals of financial assets					
· Assets carried at amortised cost	0	0	0	0	
· Assets carried at cost	0	0	0	0	
· Available for sale financial assets	0	0	0	0	
Impairments and reversals of non-current assets held for sale	0	0	0	0	
Impairments and reversals of investment properties	0	0	0	0	
Audit fees	86	86	0	86	
Other non statutory audit expenditure					
· Internal audit services	0	0	0	0	
· Other services	0	0	0	0	
General dental services and personal dental services	0	0	0	0	
Prescribing costs	80,513	0	80,513	81,677	
Pharmaceutical services	0	0	0	0	
General ophthalmic services	475	0	475	470	
GPMS/APMS and PCTMS	5,779	0	5,779	3,550	
Other professional fees excl. audit	204	101	103	158	
Grants to Other bodies	323	0	323	246	
Clinical negligence	8	8	0	10	
Research and development (excluding staff costs)	20	0	20	20	
Education and training	293	21	272	137	
Change in discount rate	0	0	0	0	
Provisions	358	160	198	708	
Funding to group bodies	0	0	0	0	
CHC Risk Pool contributions	447	0	447	1,117	
Other expenditure	0	0	0	0	
Total other costs	**722,104**	**4,636**	**717,468**	**696,649**	
Total operating expenses	**729,558**	**11,346**	**718,212**	**702,801**	

Notes

1. 2015-16 Purchase of healthcare from non-NHS bodies (£1,979,000) now within Transport following clarification of guidance from NHS England

6.1 Better Payment Practice Code

Measure of compliance	**2016-17 Number**	**2016-17 £'000**	2015-16 **Number**	2015-16 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	20,076	124,357	15,480	112,703
Total Non-NHS Trade Invoices paid within target	20,026	124,242	15,386	111,739
Percentage of Non-NHS Trade invoices paid within target	**99.75%**	**99.91%**	**99.39%**	**99.14%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,617	499,887	3,289	490,873
Total NHS Trade Invoices Paid within target	3,604	499,860	3,230	485,076
Percentage of NHS Trade Invoices paid within target	**99.64%**	**99.99%**	**98.21%**	**98.82%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2016-17 £'000**	2015-16 £'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 2016/17.

8. Investment revenue
The Clinical Commissioning Group did not have any Investment Revenue as at 31 March 2017.

9. Other gains and losses
The Clinical Commissioning Group did not have any other gains and losses as at 31 March 2017.

10. Finance costs
The Clinical Commissioning Group did not have any Finance Costs as at 31 March 2017.

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 2017.

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Service Ltd. In 2016-17, 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

	2016-17				2015-16			
	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	824	24	**848**	0	699	11	**710**
Contingent rents	0	0	0	**0**	0	0	0	**0**
Sub-lease payments	0	0	0	**0**	0	0	0	**0**
Total	**0**	**824**	**24**	**848**	**0**	**699**	**11**	**710**

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

12.1.2 Future minimum lease payments

	2016-17				2015-16			
	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	32	**32**
Between one and five years	0	0	12	**12**	0	0	36	**36**
After five years	0	0	0	**0**	0	0	0	**0**
Total	**0**	**0**	**32**	**32**	**0**	**0**	**68**	**68**

12.2 As lessor

The Clinical Commissioning Group did not have any leases let as at 31 March 2017.

13 Property, plant and equipment

2016-17	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 2016	0	0	0	0	0	0	427	112	539
Addition of assets under construction and payments on account				0					0
Additions purchased	0	0	0	0	0	0	48	2	50
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**475**	**114**	**589**
Depreciation 01 April 2016	0	0	0	0	0	0	145	0	145
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	56	18	74
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**201**	**18**	**219**
Net Book Value at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**274**	**96**	**370**
Purchased	0	0	0	0	0	0	274	96	370
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**274**	**96**	**370**
Asset financing:									
Owned	0	0	0	0	0	0	274	96	370
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**274**	**96**	**370**

Revaluation Reserve Balance for Property, Plant & Equipment

The Clinical Commissioning Group did not have any Revaluation Reserve Balance as at 31 March 2017.

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 2017.

13.2 Donated assets
The Clinical Commissioning Group did not hold any donated assets at 31 March 2017.

13.3 Government granted assets
The Clinical Commissioning Group did not hold any government granted assets at 31 March 2017.

13.4 Property revaluation
The Clinical Commissioning Group did not have any property revaluation at 31 March 2017.

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 2017.

13.6 Write downs to recoverable amount

The Clinical Commissioning Group did not have any assets written down to recoverable amounts at 31 March 2017.

13.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2017.

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 2017.

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

2016-17	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 2016	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 2017	**20**	**0**	**0**	**0**	**0**	**20**
Amortisation 01 April 2016	3	0	0	0	0	3
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 2017	**7**	**0**	**0**	**0**	**0**	**7**
Net Book Value at 31 March 2017	**13**	**0**	**0**	**0**	**0**	**13**
Purchased	13	0	0	0	0	13
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2017	**13**	**0**	**0**	**0**	**0**	**13**

Revaluation Reserve Balance for intangible assets
The Clinical Commissioning Group did not have any Revaluation Reserve Balance as at 31 March 2017.

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 2017.

14.2 Government granted assets
The Clinical Commissioning Group did not hold any intangible non-current government granted assets at 31 March 2017.

14.3 Revaluation
The Clinical Commissioning Group did not have a revaluation at 31 March 2017.

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 2017.

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 2017.

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 2017.

14.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2017.

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 2017.

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 2017.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2016	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 2017	**0**	**0**	**2**	**0**	**0**	**0**	**2**

17 Trade and other receivables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
NHS receivables: Revenue	3,128	0	305	0
NHS receivables: Capital	0	0	0	0
NHS prepayments	2,177	0	2,132	0
NHS accrued income	138	0	1,138	0
Non-NHS and Other WGA receivables: Revenue	616	0	766	0
Non-NHS and Other WGA receivables: Capital	0	0	0	0
Non-NHS and Other WGA prepayments	854	0	739	0
Non-NHS and Other WGA accrued income	104	0	329	0
Provision for the impairment of receivables	0	0	0	0
VAT	667	0	78	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	**7,684**	**0**	**5,487**	**0**
Total current and non current	**7,684**		**5,487**	
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	**2016-17 £'000**	2015-16 £'000
By up to three months	1,242	448
By three to six months	139	38
By more than six months	192	139
Total	**1,573**	**625**

£594,559 of the amount above has subsequently been recovered post the statement of financial position date.

17.2 Provision for impairment of receivables	**2016-17 £'000**	2015-16 £'000
Balance at 01 April 2016	0	0
Amounts written off during the year	0	0
Amounts recovered during the year	0	0
(Increase) decrease in receivables impaired	0	0
Transfer (to) from other public sector body	0	0
Balance at 31 March 2017	**0**	**0**

	2016-17 £'000	2015-16 £'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 2017.

19 Other current assets
The Clinical Commissioning Group did not have any other current assets as at 31 March 2017.

20 Cash and cash equivalents

	2016-17 £'000	2015-16 £'000
Balance at 01 April 2016	50	50
Net change in year	(1)	0
Balance at 31 March 2017	**49**	**50**
Made up of:		
Cash with the Government Banking Service	49	50
Cash with Commercial banks	0	0
Cash in hand	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	**49**	**50**
Bank overdraft: Government Banking Service	0	0
Bank overdraft: Commercial banks	0	0
Total bank overdrafts	**0**	**0**
Balance at 31 March 2017	**49**	**50**
Patients' money held by the clinical commissioning group, not included above	0	0

21 Non-current assets held for sale
The Clinical Commissioning Group did not have any non-current assets held for sale as at 31 March 2017.

22 Analysis of impairments and reversals
The Clinical Commissioning Group did not make any impairments in 2016-17

23 Trade and other payables	**Current 2016-17 £'000**	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'000
Interest payable	0	0	0	0
NHS payables: revenue	2,532	0	1,880	0
NHS payables: capital	0	0	0	0
NHS accruals	1,453	0	1,204	0
NHS deferred income	0	0	0	0
Non-NHS and Other WGA payables: Revenue	7,687	0	6,546	0
Non-NHS and Other WGA payables: Capital	0	0	252	0
Non-NHS and Other WGA accruals	24,527	0	19,100	0
Non-NHS and Other WGA deferred income	0	0	0	0
Social security costs	99	0	76	0
VAT	0	0	0	0
Tax	82	0	82	0
Payments received on account	0	0	0	0
Other payables and accruals	798	0	857	0
Total Trade & Other Payables	**37,178**	**0**	**29,997**	**0**
Total current and non-current	**37,178**		**29,997**	

Other payables include £122,315 outstanding pension contributions at 31 March 2017

24 Other financial liabilities
The Clinical Commissioning Group did not have any other financial liabilities as at 31 March 2017.

25 Other liabilities
The Clinical Commissioning Group did not have any other liabilities as at 31 March 2017.

26 Borrowings
The Clinical Commissioning Group did not have any borrowings as at 31 March 2017.

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 2017.

28 Finance lease obligations
The Clinical Commissioning Group did not have any finance lease obligations as at 31 March 2017.

29 Finance lease receivables
The Clinical Commissioning Group did not have any finance lease receivables as at 31 March 2017.

29.1 Finance leases as lessor
The Clinical Commissioning Group did not have any unguaranteed residual value accruing as at 31 March 2017.
The Clinical Commissioning Group did not have any accumulated allowance for uncollectible lease receivables as at 31 March 2017.

30 Provisions

	Current 2016-17 £'000	**Non-current 2016-17 £'000**	Current 2015-16 £'000	Non-current 2015-16 £'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	597	0	702	0
Other	182	0	208	0
Total	**779**	**0**	**910**	**0**
Total current and non-current	**779**		**910**	

	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 2016	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**702**	**208**	**910**
Arising during the year	0	0	0	0	0	0	0	594	160	754
Utilised during the year	0	0	0	0	0	0	0	(303)	(186)	(489)
Reversed unused	0	0	0	0	0	0	0	(396)	0	(396)
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**597**	**182**	**779**
Expected timing of cash flows:										
Within one year	0	0	0	0	0	0	0	597	182	779
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 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**597**	**182**	**779**

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 provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £33k

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

31 Contingencies

	2016-17 £'000	2015-16 £'000
Contingent liabilities		
Equal Pay	0	0
NHS Litigation Authority Legal Claims	0	0
Employment Tribunal	0	0
NHSLA employee liability claim	0	0
Redundancy	0	0
Continuing Healthcare	140	92
Litigation	0	0
Her Majesty's Revenue and Customs	32	42
Net value of contingent liabilities	**172**	**134**
Contingent assets		
Amounts payable against contingent assets	0	0
Net value of contingent assets	**0**	**0**

32 Commitments

32.1 Capital commitments

The Clinical Commissioning Group did not have any contracted capital commitments not otherwise included in these financial statements as at 31 March 2017.

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 2017.

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's 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.

33.1.3 Credit risk

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

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

33.3 Financial liabilities

	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**

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

34 Operating segments

	Gross expenditure £'000	Income £'000	Net expenditure £'000	Total assets £'000	Total liabilities £'000	Net assets £'000
NHS Somerset Clinical Commissioning Group	729,558	(3,058)	**726,500**	8,118	(37,957)	**(29,839)**
Total	**729,558**	**(3,058)**	**726,500**	**8,118**	**(37,957)**	**(29,839)**

34.1 Reconciliation between Operating Segments and SoCNE

	2016-17 £'000
Total net expenditure reported for operating segments	726,500
Total net expenditure per the Statement of Comprehensive Net Expenditure	**726,500**

34.2 Reconciliation between Operating Segments and SoFP

	2016-17 £'000
Total assets reported for operating segments	8,118
Total assets per Statement of Financial Position	**8,118**

	2016-17 £'000
Total liabilities reported for operating segments	(37,957)
Total liabilities per Statement of Financial Position	**(37,957)**

35 Pooled budgets

The Clinical Commissioning Group had entered into a pooled budget with Somerset County Council. The pool is hosted by Somerset County Council.
Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Learning Disability Service, the Integrated Community Equipment Service and the Carers Support Service.

2016/2017 POOLED BUDGET MEMORANDUM OF ACCOUNTS

Integrated Community Equipment Service		2015/16 £	2016/17 £
Income from:			
	Adults & Health Services	1,116,079	1,236,320
	Children & Learning Services	320,759	320,270
	Clinical Commissioning Group (Inclu. CHC Inc) [1]	1,455,669	1,393,010
	Better Care Fund	1,200,000	1,305,000
	Other Income		
Total funding		4,092,507	4,254,600
Expenditure:			
	Equipment, Delivery, Minor Works [2]	4,243,488	4,097,810
	Management and Administration	93,209	95,790
Total Expenditure		4,336,697	4,193,600
Variation		244,190	(61,000)

Notes:

[1] Includes £336,160 CHC Income.
[2] Includes £378,200 Creditor Provision. No Debtor Provision was made.
[3] 50% of the underspend has been returned to CCG (£30,500).

Carers Pooled Budget		2015/16 £	2016/17 £
Income from:			
	Adults & Health Services	203,500	223,500
	Care Act Funding	47,630	0
	Clinical Commissioning Group	204,000	231,112
	Health & Wellbeing Grant	1,250	0
	Other Income	0	250
	Funding Carried Forward	38,909	58,651
Total Funding		495,289	513,513
Expenditure:			
	Universal Carers Support Service	407,500	407,500
	Carers Support Worker Salary/Running Costs	29,138	25,613
	CAMHS Carers Assessment Workers	0	47,612
	Earmarked Reserve	58,651	32,788
Total Expenditure		495,289	513,513
Variation		0	0

Notes:

[1] £25,863 has been drawn down from the earmarked reserve in 16/17. The reserve has a balance of £32,788.
[2] No Creditor or Debtor Provision has been made.

Learning Disabilities Services		2015/16 £	2016/17 £
Income from:			
	Adults & Health Services	49,370,400	48,731,000
	Pensions Equalisation Reserve	383,000	0
	Clinical Commissioning Group	18,248,577	18,148,352
	Somerset Partnership	0	14,177
	Better Care Fund	550,000	0
	Income From Charges & Grant Income	6,860,616	7,047,425
Total Funding		75,412,593	73,940,954
Expenditure:			
	Purchasing (Independent Sector)	45,528,788	49,784,128
	Residential Services	9,899,473	10,079,081
	Supported Housing	13,111,017	13,450,303
	Day Services	7,162,817	7,331,081
	Community Teams	1,278,654	1,177,473
	Mental Capacity	250,162	325,500
Total Expenditure		77,230,911	82,147,566
Variation		1,818,318	8,206,612

Notes:

[1] Creditor provision of £2,188,587.37 has been made.
[2] Debtor provision of -£1,514,512.41 has been made, including the CCG recharge.
[3] PIA provision of -£644,257.60 has been made.
[4] RIA provision of £256,471.55 has been made.
[5] No Debt Impairment has been made.
[6] £680,579 of the CCG contribution to the overspend has been funded from the Better Care Fund.

Certificate of Group Manager - Finance, Community Services Directorate

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

M. J. Young

……

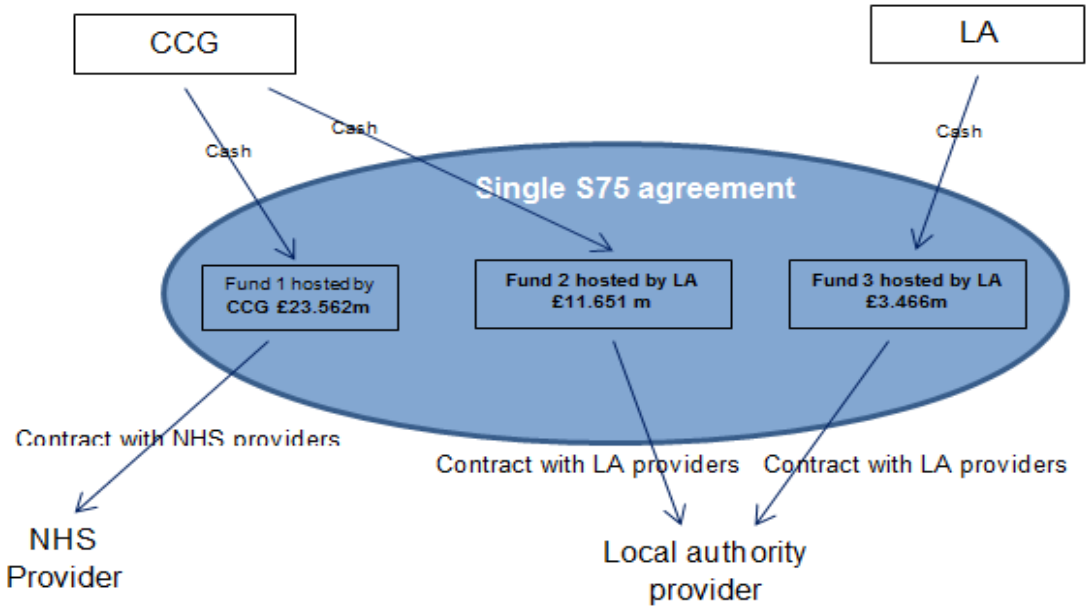
Martin Young
Strategic Finance Manager – Adults & Childrens
Somerset County Council

35 Pooled Budgets cont'd

The Better Care Fund in Somerset

In 2015/16 the Better Care Fund was established by the Government to provide funds to local areas to support the integration of health and social care and to seek to achieve the National Conditions and Local Objectives. It is a requirement of the Better Care Fund that NHS Somerset Clinical Commissioning Group (the CCG) and Somerset County Council establish a pooled fund for this purpose, which has been achieved in 2016/17 through a signed agreement under Section 75 of the National Health Service Act 2006.

Under this Section 75 agreement there are three funds totalling £38.679m and hosted by whichever body undertook the contracting arrangements. These funds support the four schemes supported by the Better Care Fund namely Reablement, Person-centred care, Improved DToC Arrangements and Housing Adaptions. The Somerset Better Care Fund arrangement is shown diagrammatically and described below: -



Actual Expenditure 2016/17	Fund 1	Fund 2	Fund 3	BCF Total
	£'000	£'000	£'000	£'000
Scheme A – Reablement & other social care schemes	2,858	11,447		14,305
Scheme B – Person-centred care	20,704	204		20,908
Scheme C – Improved DToC Arrangements				
Scheme D – Housing Adaptions			3,466	3,466
Total per Fund	**23,562**	**11,651**	**3,466**	**38,679**

Scheme C – Improved DToC Arrangements

The funding for this scheme totalling £0.38m has come from existing Commissioner and Provider allocations and has been accounted for outside of the Better Care Fund. The contribution of the Clinical Commissioning Group was £0.145m, Taunton & Somerset NHS Foundation Trust £0.146m, Yeovil District Hospital NHS Foundation Trust £0.065m and Somerset County Council £0.024m.

Fund 1 is hosted by the Clinical Commissioning Group and totals £23.562m. The fund includes contributions from the CCG only, which have been paid to providers contracted to support the Reablement and Person-centred care. The 16/17 plan assumes payments made from the CCG to Somerset Partnership NHS Foundation Trust £9.417m Taunton & Somerset NHS Foundation Trust £8.276m and Yeovil District Hospital NHS Foundation Trust £5.869m.The CCG controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 agreement.

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

Fund 2 is hosted by Somerset County Council and totals £11.651m. This fund includes a small amount of funding, £203,500, which is the CCGs contribution to the Carers Pooled budget.

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

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

Fund 3 is hosted by Somerset County Council and totals £3.466m. The fund includes contributions from the County Council only, which have been paid to providers contracted to support the Housing Adaptions schemes. The County Council controls this fund in its entirety and wholly owns any risk relating to this fund as per the Section 75 agreement.

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

36 NHS Lift investments

The Clinical Commissioning Group did not have any NHS LIFT investments as at 31 March 2017.

37 Related party transactions

Details of related party transactions with individuals are as follows:

31 March 2017	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
Dr Matthew Dolman was seconded from his role as Chair to Senior Responsible Officer for the Somerset Sustainability and Transformation Plan **with effect from 01/04/16**, and is a GP Partner at Axbridge and Wedmore Medical Practice, which is a research hub practice, a member of North Sedgemoor GP Commissioning Locality, and a member of Somerset Primary Healthcare Limited. The practice uses pharmaceutical support for light buffet suppers before meetings. Dr Matthew Dolman is one of the Clinical Commissioning Group's nominated members of the Somerset County Council's Health and Wellbeing Board, and his wife is an extended scope physiotherapist at Somerset Partnership NHS Foundation Trust. Dr Matthew Dolman **resigned as chair 31/12/16**				
Axbridge & Wedmore Medical Practice	116	0	3	0
North Sedgemoor GP Commissioning Locality	0	0	0	0
Somerset County Council	37,947	1,480	3,819	429
Somerset Partnership NHS Foundation Trust	131,986	0	18	101
Somerset Primary Healthcare Limited	120	0	3	0
Vice Chair and Non Executive Director Lou Evans is a director at ARC Homes **(withdrawn 15/09/16)**, a director at Martin Brooks Associates Limited, 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. His wife is employed as an Occupational Therapist at Somerset Partnership NHS Foundation Trust. Lou Evans was interim chair from **01/04/16 to 31/05/16**				
ARC Homes **- withdrawn 15/09/16**	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	131,986	0	18	101
Yeovil District Hospital NHS Foundation Trust	85,208	0	249	619
Managing Director/ Accountable Officer David Slack is one of the Clinical Commissioning Group's nominated members of the Somerset County Council's Health and Wellbeing Board, his daughter is employed as a support worker with the Learning Disability Service at Somerset County Council and as a bank healthcare assistant by Taunton & Somerset NHS Foundation Trust **(added 23/02/17)**, his daughter-in-law is a GP trainee at Severn Deanery **(added 15/09/16)**				
Severn Deanery - **added 15/09/16**	0	0	0	0
Somerset County Council	37,947	1,480	3,819	429
Taunton & Somerset NHS Foundation Trust - **added 23/02/17**	182,735	0	10	1,591
Chair Dr Ed Ford was appointed as Chair **from 01/01/17,** having been interim chair **from 01/06/16. Dr Ford** was Chair of the Clinical Operations Group until **31/12/16**, and 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 one of the Clinical Commissioning Group's nominated members of the Somerset County Council's 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), and works shifts in the 999 GP Project. His wife is Lead Nurse for the Age UK 'Living Better Together' project based in West Somerset.				
Age UK	0	0	0	0
Irnham Lodge Surgery	252	0	167	0
Somerset Accident Voluntary Emergency Service	0	0	0	0
Somerset Partnership NHS Foundation Trust	131,986	0	18	101
Somerset Primary Healthcare Limited	120	0	3	0
South Western Ambulance Service NHS Foundation Trust	20,683	0	0	2
West Somerset GP Commissioning Locality	0	0	0	0
GP Dr Geoff Sharp is a GP Partner at The Park Medical Partnership a PMS Practice which is also a provider to Shepton Mallet Community Hospital under contract from Somerset Partnership NHS Foundation Trust, is the Chair of Central Mendip GP Commissioning Locality, provides out of hours services to Somerset Doctors Urgent Care (formerly to South Western Ambulance Service NHS Foundation Trust) and has an interest in Somerset Primary Healthcare Limited.				
Central Mendip GP Commissioning Locality	0	0	0	0
Park Medical Partnership, PMS Practice	103	0	0	0
Somerset Doctors Urgent Care (Part of the Vocare Group)	7,220	113	0	14
Somerset Partnership NHS Foundation Trust	131,986	0	18	101
Somerset Primary Healthcare Limited	120	0	3	0
GP Dr Iain Phillips is a GP Partner at Wincanton Health Centre & Somerton Surgery which is a Member of South Somerset Commissioning Locality, is a Director and Shareholder of Pathways Health and Social Care Alliance Ltd, is a Director and Shareholder of Wincanton Healthcare Ltd, of which Wincanton Health Centre is a provider of medical services to Wincanton Community Hospital, which is part of Somerset Partnership NHS Foundation Trust, and has an interest in Somerset Primary Healthcare Limited. Dr Iain Phillips **resigned 30/06/16**				
Pathways Health and Social Care Alliance Ltd	0	0	0	0
Somerset Partnership NHS Foundation Trust	131,986	0	18	101
Somerset Primary Healthcare Limited	120	0	3	0
Somerton Surgery	183	1	0	0
South Somerset Commissioning Locality	0	0	0	0
Wincanton Health Centre	125	0	1	0
Wincanton Healthcare Limited	0	0	0	0
Non Executive Director and Secondary Care Specialist Doctor Dr Sean O'Kelly is the Medical Director at University Hospitals Bristol NHS Foundation Trust, is a special advisor for the Care Quality Commission, is an expert advisor on clinical governance and quality improvement for the World Health Organisation, his wife is a salaried GP at Lechlade Medical Centre Gloucestershire. Dr Sean O'Kelly **resigned 31/12/16**				
University Hospitals Bristol NHS Foundation Trust	8,967	0	551	5
Care Quality Commission	0	0	0	0
Lechlade Medical Centre	0	0	0	0

World Health Organisation	0	0	0	0
Chief Finance Officer and Director of Performance Alison Henly 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 **(added 15/09/16)**, an Observer of the Board of Somerset Activity and Sports Partnership and her sister is employed by Care Focus **(withdrawn 15/09/16)**.				
Care Focus **- withdrawn 15/09/16**	19	0	0	0
Somerset Activity and Sports Partnership	0	0	0	0
Somerset County Council	37,947	1,480	3,819	429
Non-Executive Director Eileen Tipper is a director of the Children & Young People's Partnership In Somerset (CHYPPS), is a member of Somerset Children's Trust Board at Somerset County Council and a member of the Policy and People Scrutiny Committee at Somerset County Council. **Eileen Tipper resigned 31/03/17**				
Children & Young People's Partnership In Somerset	0	0	0	0
Somerset County Council	37,947	1,480	3,819	429
Director of Clinical and Collaborative Commissioning Ann Anderson has no interests to declare. Ann Anderson **retired 31/03/17**				
Director of Commissioning Reform Paul Goodwin has a daughter-in-law who is an employee of PricewaterhouseCoopers LLP, and is the Clinical Commissioning Groups representative on the South West Academic Health Science Network Membership Council **(added 17/11/16)**.				
PricewaterhouseCoopers LLP	319	0	0	0
South West Academic Health Science Network **- added 17/11/16**	18	4	0	0
Non Executive Director Peter Rowe was the Chair of the Somerset County Patient Participation Group Chairs Network and later became the representative of the Somerset County Patient Participation Group Chairs Network **(updated 26/01/17)**				
County PPG Chairs' Group	0	0	0	0
Local Medical Committee Observer Dr Harry Yoxall is the Medical Secretary of the Somerset Local Medical Committee and his wife is sessional GP in the Accident & Emergency department at Taunton & Somerset NHS Foundation Trust				
Somerset LMC	0	0	0	0
Taunton & Somerset NHS Foundation Trust	182,735	0	10	1,591
Director of Quality, Safety and Governance Lucy Watson is a Specialist Professional Advisor for the Care Quality Commission. **Lucy Watson retired 31/10/16**				
Care Quality Commission	0	0	0	0
Director of Systems Transformation Steven Foster **(resigned 27/01/17)** is a joint post with Somerset County Council.				
Somerset County Council	37,947	1,480	3,819	429
Non-Executive Director and Registered Nurse Jayne Chidgey-Clark **(added 26/05/16)** is a director of JCC Partnership Limited, a trustee of the Rosetta Life charity **(withdrawn 30/03/17)** 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 and her daughter is an employee of PricewaterhouseCoopers. Jayne Chidgey-Clark is the Clinical Commissioning Group's nominated Governor of Somerset Partnership NHS Foundation Trust **(added 17/11/16)**				
JCC Partnership Limited	0	0	0	0
NHS England	504	469	2	2,314
NHS North Somerset Clinical Commissioning Group	0	0	8	0
PricewaterhouseCoopers LLP	319	0	0	0
Rosetta Life Charity **- withdrawn 30/03/17**	0	0	0	0
Somerset Partnership NHS Foundation Trust **- added 17/11/16**	131,986	0	18	101
GP and Interim Chair of the Clinical Operations Group (**appointed 01/06/16, resigned 31/12/16)** Dr Stephen Gardiner is a GP Partner at East Quay Medical Centre which is a member of Bridgwater Bay Health Commissioning Locality and a shareholder in Somerset Primary Healthcare Limited. Dr Stephen Gardiner is a director and shareholder of East Quay Health Limited, provider of minor surgery in Bridgwater, and East Quay Vision Limited, an optometry practice in Bridgwater. His daughter is a staff nurse at Bristol Heart Institute, part of University Hospitals Bristol				
Bridgwater Bay Health Commissioning Locality	22	0	0	0
East Quay Health Limited	98	0	10	0
East Quay Medical Centre	111	0	0	0
East Quay Vision Limited	49	0	0	0
Somerset Primary Healthcare Limited	120	0	3	0
University Hospitals Bristol NHS Foundation Trust	8,967	0	551	5
GP Dr Will Harris (**added 20/10/16)** is a GP Partner at Wells Health Centre which is a member of West Mendip Commissioning Locality and a shareholder of Somerset Primary Healthcare Limited. Dr Will Harris is the LMC representative for the Mendip area (**withdrew 30/03/17)**. Dr Will Harris was appointed Chair of the Clinical Operations Group **from 01/01/17**				
Somerset Local Medical Committee - **removed 30/03/17**	172	3	35	0
Somerset Primary Healthcare Limited	120	0	3	0
Wells Health Centre	215	1	0	0
West Mendip Commissioning Locality	0	0	0	0
Healthwatch Representative Judith Goodchild (**added 20/10/16)** is a member of the Health and Wellbeing Board and Public Governor of Taunton & Somerset NHS Foundation Trust representing West Somerset				
Somerset County Council	37,947	1,480	3,819	429
Taunton & Somerset NHS Foundation Trust	182,735	0	10	1,591
Interim Director of Quality and Patient Safety Deborah Rigby **(17/10/16 to 04/12/16)** is registered as a specialist nurse with Bupa and sees a small number of private patients at Bath Clinic or Spire Bristol once per quarter				
BUPA	349	0	20	0
Spire Healthcare	66	0	0	0
Director of Quality and Patient Safety Sandra Corry **(appointed 24/11/16)** has a 5% share in spouse's consultancy company QSI Limited which provides support to Health and Social Care sectors				
QSI Limited	0	0	0	0
Non-Executive Director and Secondary Care Doctor Basil Fozard **(appointed 01/01/17)** has no interests to declare.				

Note

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

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

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

(iii) are a member of the key management personnel

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

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

31 March 2017	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
NHS England	504	469	2	2,314
South, Central and West Commissioning Support	3,395	0	305	22
NHS FOUNDATION TRUSTS				
Dorset County Hospital NHS Foundation Trust	2,123	0	0	145
Royal Brompton & Harefield NHS Foundation Trust	404	0	20	0
Royal Devon and Exeter NHS Foundation Trust	4,759	0	51	3
Royal United Hospital Bath NHS Foundation Trust	30,095	0	266	172
Salisbury NHS Foundation Trust	662	0	0	0
Somerset Partnership NHS Foundation Trust	131,986	0	18	101
South Western Ambulance Service NHS Foundation Trust	20,683	0	0	2
Taunton and Somerset NHS Foundation Trust	182,735	0	10	1,591
University Hospitals Bristol NHS Foundation Trust	8,967	0	551	5
Yeovil District Hospital NHS Foundation Trust	85,208	0	249	619
NHS TRUSTS				
North Bristol NHS Trust	6,972	0	0	15
Northern Devon Healthcare NHS Trust	478	0	0	4
Weston Area Health NHS Trust	15,033	0	506	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 2017.

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:

	2016-17 Target £'000	**2016-17 Performance £'000**	2015-16 Target £'000	2015-16 Performance £'000
Expenditure not to exceed income	6,484	(3,016)	6,484	6,484
Capital resource use does not exceed the amount specified in Directions	50	50	252	252
Revenue resource use does not exceed the amount specified in Directions	723,484	726,500	705,664	699,180
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	50	50	252	252
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	711,611	715,392	692,635	687,349
Revenue administration resource use does not exceed the amount specified in Directions	11,873	11,108	13,029	11,831

41 Impact of IFRS
Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2016-17 financial year

42 Analysis of charitable reserves

	2016-17 £'000	2015-16 £'000
Unrestricted funds	0	0
Restricted funds	0	0
Endowment funds	0	0
Total	**0**	**0**