NHS
Somerset
Clinical Commissioning Group

ANNUAL REPORT 2018/19

23 May 2019

NHS Somerset CCG Annual Report 2018/19

Contents

PERFORMANCE REPORT

David Freeman

Chief Officer

23 May 2019

1. Introduction

The past twelve months have been a very important time for us and the people and communities we serve. There are ever growing demands across all health and care services as well as mounting pressures on our staff and our finances. Despite this, our year has been one of positive progress and sustained improvement.

We are not unique in the challenges that we face – the NHS as a whole is facing an unprecedented period of change and transformation. In fact the only constant in the NHS is change and we need to accept and embrace this. As the needs of our population change, so must our services so that we can provide better care and better access to care.

While we remain in special measures (having been rated as inadequate in 2017) we have made significant progress in improving the financial position in Somerset and making sure that health services are safe and available when people need them. We are now rated as requires improvement and we are working towards a rating of good. This positive achievement is testament to the hard work of all our staff.

Our vision is simple. We want to work together to improve the health and wellbeing of everyone who lives and works in Somerset. We can only do this if we work together with our partners in the health and care system and with our patients and the public. Bringing health and care together in a way that is sustainable, while also making improvements to how we deliver services is not going to be easy but we know we need to do this to build stronger communities with services which support people to live happy, healthy lives.

At the heart of every decision is our commitment to deliver the health and care services the people of Somerset expect and deserve while delivering a sustainable financial position for the present and for the future. Together with our partners we have made good progress in developing the health and care strategy for Somerset known as Fit for My Future. The new strategy is based on clinical need and will address the current health inequalities in the county while also being financially affordable.

As part of the development of the strategy we have already begun conversations with patients, staff, the public and stakeholders about what matters most to them. We will continue these conversations as we develop our proposals, many of which will go out to public consultation later this year and in 2020.

We also recognise that we need to go further in involving people more fully in the way we develop services. We are taking steps to ensure we listen more carefully to the people who live or work in Somerset and to develop new ways of working to make sure the voices of our people are heard. We are committed to making sure that the patient and public voice is at the heart of everything we do as move forward together.

We would like to take this opportunity to thank our staff, volunteers, partners, providers and Governing Body for their hard work and dedication over the past year. Their continued commitment helps us to make sure that we are all working together to improve the health and wellbeing of everyone in Somerset.

This year we all proudly celebrated 70 years of the NHS. The NHS has transformed the health of the nation and continues to be the most trusted organisation in the country. We support and care for people throughout their whole lives. We are there when they are at their lowest ebb, in their darkest moments and also by their side at times of great joy. There is a lot to celebrate in the NHS's past. Our priority though must be its future. By working together with our partners we will make sure that health and care services in Somerset are fit for all our futures.

Dr Ed Ford
Chair

David Freeman
Chief Officer

1.1. Statement from the Somerset Sustainability and Transformation Partnership (STP)

We know that the future sustainability of services rests in a partnership approach with all health, care and community partners in Somerset.

During 2018/19 we made great progress on developing joined up plans as part of working towards a single system approach. Partners in the system have shared financial activity and workforce details in order to help us develop aligned strategies and delivery plans. The outcome has been a set of plans that delivered against key ambitions during the year and in laying the foundations for further integrated working in 2019/20.

Combining the Health & Wellbeing Strategy ('Improving Lives') and the health and care services strategy ('Fit for my Future') we are increasingly able to join up our ways of working, our resources and our long term transformation plans. To support this, in 2018/19 we developed a joint three-year financial recovery plan which drew together our ambitions for clinically and financially sustainable health and care in Somerset.

The plans have informed the development of our joint approach for Somerset in 2019/20 which focus on managing demand and reducing cost across the system.

In partnership with others, one of the CCG's key priorities in 2019/20 is to reduce unwarranted variation across our county. We are using national data and benchmarking (in the form of nationally published data packs (such as Rightcare, Getting It Right First Time, Model Hospital and Best Practice Reference Costs) to look at elective and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care. We are also planning a system-wide approach to the efficient and cost effective use of bed capacity across all STP Partners.

Alongside this, the partners are also looking at how best to develop our commissioning and delivery operations in order to support and embed the service changes we expect to see. During 2019/20 we will look to progress our plans to establish an Integrated Care System and Integrated Care Partnerships across the county.

1.2. Health and Care Strategy for Somerset – 'Fit for my Future'

"Fit for my Future" is a strategy for how we will support the health and wellbeing of all the people of Somerset by changing the way we commission and deliver health and care services. It is being delivered through a partnership between Somerset County Council and Somerset CCG, supported by our major NHS providers.

In 2018 we published our case for change. The detailed document can be found at www.fitformyfuture.org.uk/wp-content/uploads/2018/09/ffmf_case-for-change_report-a4_oct18.pdf and the key headlines are:

- We recognise the need for a greater focus on prevention of ill health and promotion of positive health and wellbeing
- We need to tackle inequalities
- There needs to be more integrated, holistic services based on the needs of the individual, and supporting their independence
- Resources need to be shifted from hospital inpatient services towards community based services to support people in their own homes and sustain their independence
- We recognise that mental health is as important as physical health
- We need to ensure that when people need emergency and specialist care they have the right access to the skills and expertise they need
- We need to achieve financial sustainability

Based on the case for change, key proposals have been developed to transform services – some will require full public consultation because of their scale and others can be changed more rapidly as part of on-going improvement and transformation.

The case for change and proposed changes for change were subject to a major public engagement exercise in 2018/19. This included 18 specifically arranged drop-in sessions across Somerset, over 150 events and workshops, a newsletter drop to 232,000 homes. We also used digital channels to reach more and different audiences with almost 2,000 people watching our ground-breaking Facebook Live events.

The responses have been collated into a document (www.fitformyfuture.org.uk/wp-content/uploads/2019/01/engagement-summary-phase-1.pdf) and shows:

- The majority of proposals are supported, especially care closer to home and self-care
- Concerns about centralisation of services, travel / transport, staff shortages, reduced community services
- Overwhelmingly positive support for people with acute conditions to go home as soon as possible providing there is availability of adequate care and support
- Recurring theme of early help, joined up and coordinated; people want to see holistic person-centred approach services across the county
- Equal priority in service provision for mental and physical health; need holistic approach to treat physical and mental health illnesses/conditions together

We are using the feedback to inform the further development of our plans and also to help us involvement more people in co-designing new care models and new ways of working. 2019/20 will be a significant year for health and care partners and our populations as we progress with planning and delivering change in Somerset.

2. Profile of Somerset

Somerset is the 12th largest county in England. 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. We have no large urban areas, or universities.

Our population is relatively older than the national average, and over the next 25 years while the overall population will rise by 15% we expect those over the age of 75 to double, resulting in a significant rise in demand for health and care services.

While Somerset is relatively less deprived than other parts of England there are areas with high levels of deprivation. People living in deprived areas in Somerset do not live as long as people from other areas; they are more likely to experience both physical and mental health issues. Deprivation not only impacts on the length of life but its quality. In many cases the differences with people from less deprived areas are linked to lifestyle and environmental factors, including smoking, obesity, housing, income, education and disability.

Vulnerability is also often linked to deprivation.

People in Somerset are living longer than they used to, but there is an increasing gap between life expectancy and healthy life expectancy; typically, fifteen years of life can be spent with a long-term condition or conditions.

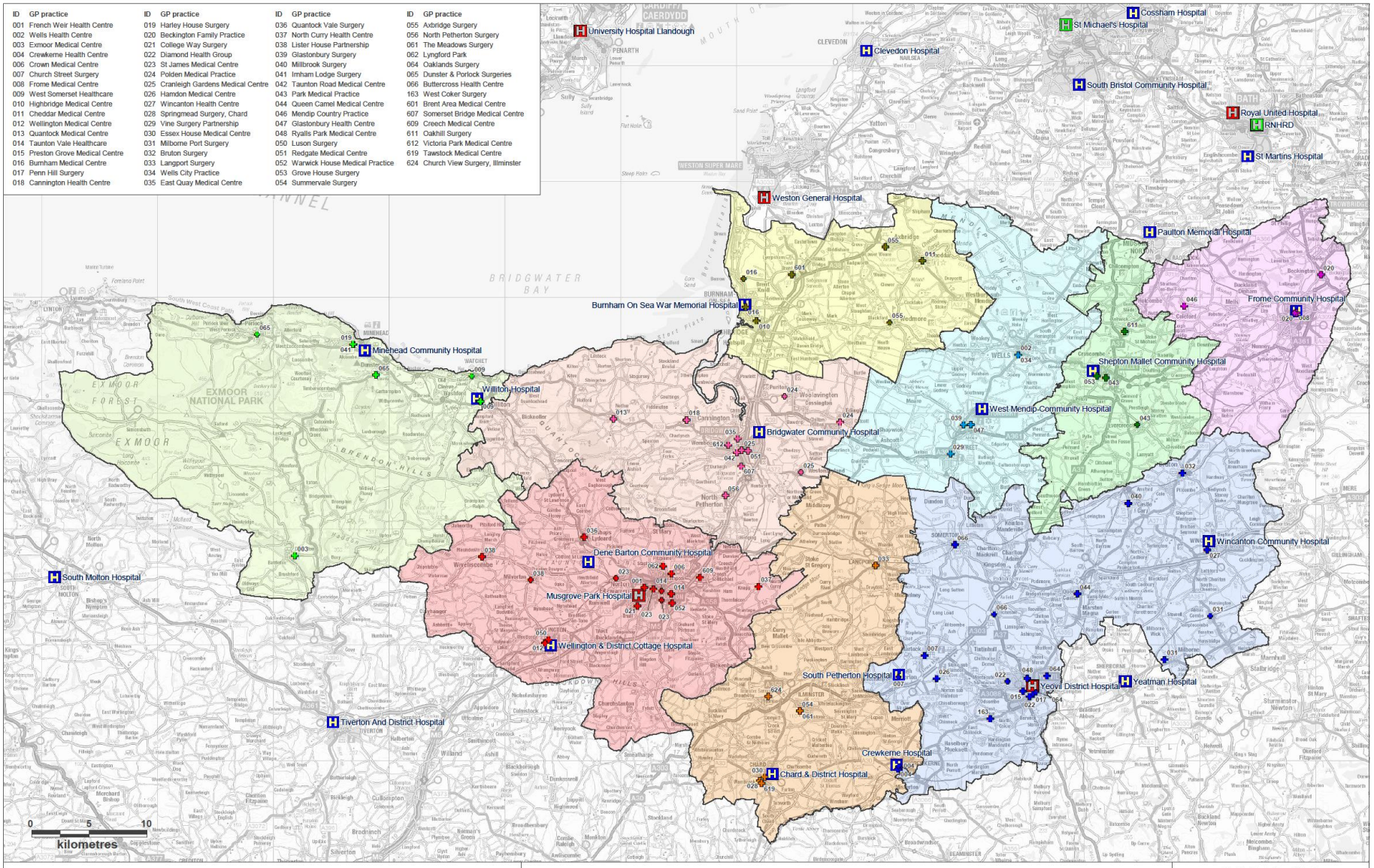
The ageing population brings new challenges:

- the older we get the more likely we are to have more than one long term condition affecting our health. Support for people with multiple conditions is more complex and needs to be much better integrated
- dementia is becoming an increasing problem and we could see a doubling of the number of people with dementia by 2035; however, lifestyle choices have a significant impact on the risk of dementia and so this could be partially mitigated

Mental health is a major issue for Somerset and affects around 70,000 people at any one time. This often influences and is influenced by multiple factors including low educational attainment, social isolation, unemployment and financial and relationship problems. People with a mental health issue often also have poor physical heath.

Lifestyle end environmental factors have a huge part to play in maintaining health and wellbeing. These include areas such as smoking, diet, exercise, social isolation, and alcohol abuse. It is estimated that lifestyle factors, environmental and societal factors together account for 60% of health issues (compared to genetic inheritance at 30% and healthcare provision at 10%).

The most important reason we need to do more to support health and wellbeing and address inequalities is the impact this will have on the quality of longevity of life for individuals. However, doing so will also help address our financial position. It costs far less to help someone stay healthy than it is does to treat and support them when they have become ill.



NHS Somerset Clinical Commissioning Group

Commissioning Localities, Hospitals and GP Surgeries

GP Practice:

- Main surgery (66)
- Branch surgery (within Somerset) (18)
- Acute Hospital
- Community Hospital
- Specialist Hospital

Commissioning Locality

- Bridgwater Bay Health
- Central Mendip
- Chard, Crewkerne & Ilminster
- East Mendip
- North Sedgemoor
- South Somerset Healthcare
- Taunton & Area
- West Mendip
- West Somerset

South, Central and West Commissioning Support Unit

NHS

scwcsu.HealthGIS@nhs.net - 5 July 2018

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3. Performance Overview

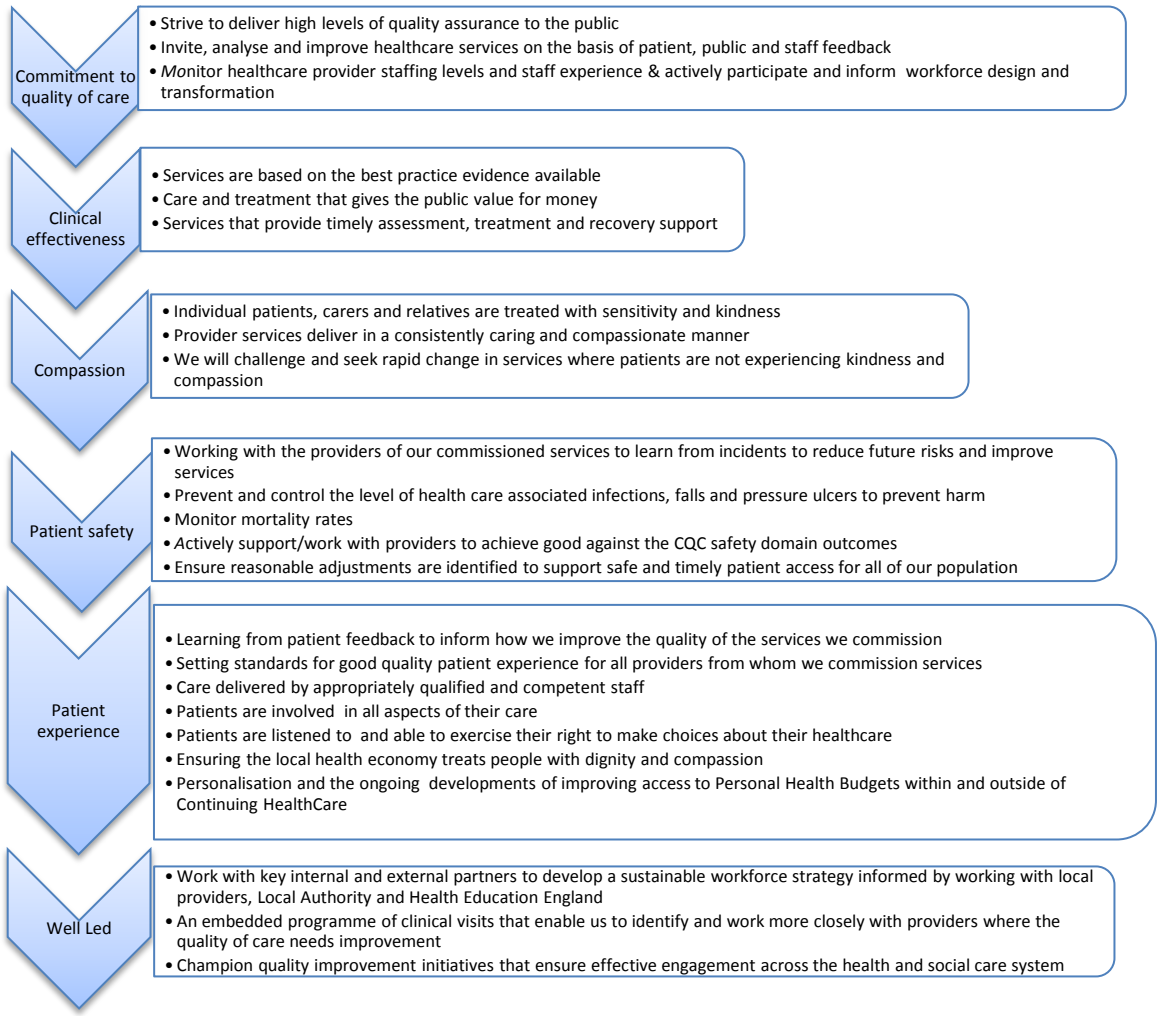
The following sections provide an overview of the purpose of the CCG, how we have performed during the year in achieving its objectives and the key risks and challenges it has faced.

The sections include how the organisation has delivered its key workstreams, statutory responsibilities and the overall performance during 2018/19.

3.1. Quality and Safety

We see the improvement of quality and patient safety to be the organising principle of our health and care services. It is what matters most to people who use the services and it is what motivates and unites everyone working in health and care. Our key focus is to ensure that quality and patient safety is built into commissioning structures, values, practices and business processes through the annual cycle of clinical quality activity.

The quality and safety of NHS Somerset CCG commissioned health services are monitored through a range of mechanisms including the Clinical Quality Review Meetings (CQRMs) held with each provider on a regular basis. In addition to analysis of the scorecard quality indicators, a range of activities are undertaken on a day to day basis to gain intelligence on the quality of service provision, to identify any 'early warning' signs of service failures and to work with partner agencies towards sustainable quality improvements. We will continue to listen to our patients and carers, and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services. We will work closely with our commissioning colleagues to ensure new models of care in line with the 5 Year Forward View, the multi-year STP and the development of greater integrated health and care systems, have quality at their core.



3.2. Prevention

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

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

What we did in 2018/19:

- an increase in investment in prevention to narrow the health and wellbeing gap in line with the STP investment plan 2018/19
- a review of the care pathways for mental health, dementia, MSK and falls, to ensure prevention is included at scale and pace and built in systematically at all levels of the care pathways
- develop and implement a system to challenge providers of health services to embed prevention throughout their services
- undertake a significant campaign to raise the public's awareness of how to self manage and access the NHS appropriately accordingly to need
- established a Cardio-Vascular Programme Board, together with Somerset County Council, which will bring together a range of key partners to help improve the prevention, detection, management and treatment of people with or at risk of cardiovascular disease

In 2018 the diabetes programme:

- implemented a face to face diabetes prevention programme
- began testing an on-line support tool called My Diabetes My Way
- implemented a pilot of one-line structured diabetes education
- set out a new integrated model of care for diabetes which will see specialist advice taken out of hospital to patients and primary care, the integration of the specialist teams and a strengthened focus on supporting patients to reverse or type 2 diabetes

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

3.3. Integrated Care

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

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

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

What we did in 2018/19:

- increased the number of patients who are supported to access voluntary sector and neighbourhood solutions as part of new models of care
- increased the number of people trained in health coaching, motivational interviewing and healthy conversations skills
- maintained a focus on person-centred care through the expansion in the testing out of the Patient Activation Measure across a number of hospital specialities
- 6 Personal Health Budgets per 1000 population:
- a greater appreciation, through Fit For My Future, about the impact of the social determinants of health and a greater recognition that many of the solutions to problems that people bring to health and care services can only be resolved by people themselves in their own lives. The development of a stronger person-first, strength-based approach which considers the person in their community is a key principle underlying our neighbourhood development programme
- we have committed to extending and rolling out social prescribing given its value in connecting people with what really matters to them, their own strengths and assets and the connections and resources available to them in the community
- importantly, integration also needs to refer to the range of local agencies in an area so that professionals are able to know each other, by name and have opportunities to develop relationships and trust. Establishing and extending the range of opportunities for local partners to form these relationships and begin working together has been an important aspect of neighbourhood working
- there have been a number of very successful joint ventures such as Home First where a wider range of organisations have become involved in supporting people to go home after a stay in hospital
- work on all the above has been increasingly approached in partnership with Somerset County Council, social care and public health teams given the shared interest in keeping people well and supporting people to have happy health lives

The Somerset Health and Care Strategy “Fit for my Future” has begun to transform how we all work together as an integrated care system. It is being delivered through a partnership between Somerset County Council and Somerset CCG, supported by our major NHS providers and will support the health and wellbeing of all the people of Somerset by changing the way we commission and deliver health and care services.

During 2018/19 we made great progress on developing joined up plans as part of working towards a single system approach. Partners in the system have shared financial activity and workforce details in order to help us develop aligned strategies and delivery plans. The outcome has been a set of plans that delivered against key ambitions during the year and in laying the foundations for further integrated working in 2019/20.

3.4. Primary Medical Care

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

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

What we did in 2018/19:

- we implemented GP Improved Access, which offers patients evening and weekend appointments at their own or another local surgery
- the GP workforce position remained difficult but through much hard work by the CCG and partner organisations including the Local Medical Committee we were able to increase the number of GPs working in Somerset from 520 in March 2018 to 542 in March 2019. We also saw a small increase in the numbers of nursing staff
- we continued to develop our approach to joining up care more effectively for patients. As part of our wider Neighbourhoods programme all GP surgeries became part of networks delivering local care with other partners
- we supported Patient Participation Groups to promote self-care and healthy living to patients and community groups
- we continued to support better technology including access to online consultations, where 22 of the 66 practices in Somerset are offering online consultations
- Somerset had no practice closures or GPs resigning from their NHS contract in 2018/19

3.5. Urgent and Emergency Care

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

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

What we did in 2018/19:

- we successfully procured a new Integrated Urgent Care (IUC) service for the county which commenced on 25 February 2019. The new IUC service incorporates NHS 111 (telephone and online), Clinical Assessment Service, face-to-face consultations and a Single Point of Access for healthcare professionals to access advice and support in relation to other services/pathways available. The 5 year contract was awarded to Devon Doctors Ltd following a comprehensive and robust procurement process. The overarching aim of the service is to complete the episode of care, where clinically appropriate, over the telephone ensuring that:

  - more patients will get the care and advice they need over the telephone or online
  - only those patients that genuinely need to attend A&E/Emergency Department or use the ambulance service are advised to do so
  - if it is not possible to resolve the patient's issue over the phone, they will be directed to the appropriate service/healthcare professional

- the Rapid Response Service was established from November 2018 which helps keep patients at home and prevent unnecessary admissions to hospital. By looking after people at home ensures they can keep their daily routines and continue to look after themselves. The service puts support in place for up to three days so that the patient can stay at home and this is provided by a team of Healthcare Assistants

- a test and learn pilot at Bridgwater Minor Injury Unit was established on 4 March 2019 to test out-of-hospital urgent care. The development of the Enhanced Minor Injury Service at Bridgwater enables testing of specific areas such as access to diagnostics, GP resource, opening hours, direct booking of appointments etc. The learning from the pilot which is taking place through 2019 will help inform the longer term strategy work of the Somerset Fit for my Future programme

- the Home First pathway is jointly commissioned from Somerset County Council and Somerset CCG. Home First continues to offer timely and appropriate interventions that produce positive outcomes for people and reduces their stay in hospital. The county has continually outperformed targets in 2018/19 and been able to maintain record low levels of Delayed Transfers of Care (DToCs)

3.6. Planned Care

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

- system-wide delivery of the constitutional standards
- reduce long wait patients
- managing demand and driving efficiencies to release additional capacity within the system to enable us to do more
- develop a new and efficient orthopaedic pathway which will deliver Referral to Treatment Time (RTT) compliance
- implement e-referrals

What we did in 2018/19:

- maintain sustainable pathway for Musculoskeletal (MSK) disorders
- identified clinical variation to aid demand and capacity challenges
- implemented 10 Pilot sites for First Contact Practitioner
- system-wide collaborative and co-ordinated response to sustain Dermatology Service across Somerset (March 2019)
- continue to monitor and manage demand, through the GP referral variation work programme
- ongoing development of driving efficiencies through the identification of clinical variation opportunities
- throughout 2018/19 e-referral work will be ongoing with other referrers such as optometrists to ensure referrals are handled in the same way
- supported success of the 100 day Endoscopy Project
- system-wide approach to minimising long wait patients

3.7. Cancer Treatment

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

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

What we did in 2018/19:

- we worked with the Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance to implement an optimal new lung cancer pathway. This means high risk patients are being seen and treated faster by being fast tracked through the diagnostic pathway
- Somerset CCG worked with the SWAG Cancer alliance to implement Faeco immunochemical testing (FIT) for people with lower risk symptoms of bowel cancer. This test is available in all Somerset GP practices
- new national guidelines for diagnosing prostate cancer have been implemented in Somerset. These aim to detect more cancers and avoid unnecessary investigations
- we have worked with Yeovil Hospital to implement a new head and neck cancer pathway which has halved waiting times
- a major transformation programme aimed at people living with and beyond cancer has been implemented in major tumour sites. This means that follow up arrangements for patients will become more personalised and fit for purpose. Patients have a detailed holistic needs assessment, access to a wellbeing event, and a cancer care review in primary care

3.8. Stroke

Summary of Stroke for 2017/18 to 2018/19:

- Early Supported Discharge for Stroke

What we did in 2018/19:

- work with the Provider to return the community inpatient beds to the existing facilities at Shepton Mallet once safe staffing levels are in place; Somerset Health and Care Strategy to explore middle to longer term plans for community service provision.
- will continue to progress towards 80% of assessed by a stroke specialist consultant within 24 hours
- in 2018, Somerset STP worked on a 100 days project in cardiology which focused on atrial fibrillation and the importance of having appropriate care pathways in place to prevent strokes

3.9. Diabetes

Summary of Diabetes for 2017/18 to 2018/19:

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

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

What we did in 2018/19:

- over 1000 patients registered in a digital diabetes prevention programme as part of a national pilot. Somerset has maintained high levels of retention in the project which reports in 2019. The face to face diabetes prevention programme commenced in Somerset which has seen significant interest
- over 200 patients participated in piloting a new method of diabetes structured education using remote access with Oviva. This has been particularly popular with men and people of working age and provided choice for newly diagnosed diabetics
- Somerset worked in partnership with My Digital Health to achieve a funding award from SBRI to implement a self- management platform for people with diabetes (My Diabetes My Way). To date 3000 patients have registered to use the site which enables them to see their records and monitor their condition online
- Somerset was awarded funding for a GP diabetes champion to review variation and support practices to improve the three NICE treatment targets. This work commenced in 2018 and will continue in 2019
- the diabetes programme worked on developing a model of care for the new integrated service. This will progress during 2019/20
- the three inpatient nurses funded from diabetes transformation funding have continued to improve care in the acute and mental health setting. This includes reducing the numbers of hypoglycaemic episodes, and ensuring people with diabetes have a plan of care

3.10. End of Life Care

Summary of End of Life Care for 2017/18 to 2018/19:

- ensure that the needs and wishes of patients at the end of life are understood and as far as clinically appropriate and practically possible, these needs and wishes are met.

What we did in 2018/19:

- improve coordination of end of life care
- increase the number of people able to die in their usual place of residence
- Implementation of an integrated system between GPs' EMIS clinical systems and the Electronic Palliative Care Coordination System (EPACCS) as part of the SIDeR programme

3.11. Mental Health

Mental health has over recent years had a much higher profile in society as a whole, and this is reflected in Government policy and initiatives.

There has been a strong emphasis on prevention; earlier intervention; better integration of services, (health and social care, primary and secondary care, mental health and physical health care); shifting the balance towards community based support; avoiding crises but managing them better when they do occur; and increasing the investment in mental health to improve the provision and outcomes of those who access support. Our aim has been to address these themes within our work programme and we are committed to working towards delivering the outcomes required to improve mental health outcomes for the population of Somerset.

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

- delivery of Early Intervention in Psychosis (EIPS) target, more than 50% of people experiencing a first diagnosis will commence NICE compliant treatment within 2 weeks of referral
- increase access to high quality mental health services for children and young people
- commission a dedicated community eating disorder service for children and young people
- to achieve the national aim of 66.7% of people living with dementia, having a formal diagnosis by 31 March 2017 (recorded in practice dementia disease register)

What we did in 2018/19:

What we said we will achieve in 18/19	What we achieved in 18/19
32% of local need for Children and Young Peoples Mental Health services to be met (Q4 2017/18)	As at March 2019 our performance against this target is 19.9%, however we still need to incorporate data from other providers and we expect the final position to be higher. We have acknowledged the shortfall in planned activity and therefore we have commissioned additional capacity from Kooth to support in achievement of this target for 2018/19
Child and Adolescent Mental Health Services (CAMHS) Transformation Plan fully implemented including Single Point of Access, Community Eating Disorder Service and the Improving Mental Health and Emotional Wellbeing in Schools service (Q1 2017/18)	Plan fully implemented, further investment has also been allocated to further support the work of Children's Eating Disorder Service during 2018/19
53% of people experiencing psychosis will commence NICE compliant treatment within 2 weeks of referral (Q1 2017/18)	This has been achieved to date within 2018/19
Maintain dementia diagnosis rate of 66.7%, for people aged 65 and over with a diagnosis of dementia recorded in primary care	Diagnosis rates remain at 62% across Somerset, further work is being determined to further address this and is a proposal within the Fit for My Future Strategy work

3.12. Learning Disabilities and Autism

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

- refresh of the Transforming Care Plan for 2017/18
- creation of bespoke community placements: promoting choice such as home ownership within the local market
- develop a Somerset framework for reviews of deaths of people with learning disabilities working with the Learning Disabilities Mortality Review (LeDeR) project
- increase joint working across health and social care using the SAF (Self-Assessment Framework)
- develop the Somerset LD Partnership Board – started in September 2016 and ongoing
- adherence to a robust Care and Treatment Review (CTR) process

What we did in 2018/19:

- develop close working links and partnership working (as set out in the refreshed Transforming Care Plan) with Somerset Partnership, as a specialist health provider, local specialist social care providers as well as local housing providers and the voluntary sector to enable people from the Transforming Care patient group to return and live in their local community in-line with the Building the Right Support service model. This has included extensive market development work and the creation of so-called 'boutique providers'
- since the start of the Transforming Care programme (February 2016) Somerset CCG, as part of the Somerset Transforming Care Partnership, has discharged 11 patients back into the community and has successfully obtained capital funding for 7 patients as well as getting funding for promoting the Home Ownership for People with Long-Term disabilities (HOLD) scheme
- we chair all CTR and Care, Education and Treatment Reviews (CETRs), although a priority area is the improved identification of those young people who require a blue light meeting or CETR
- for adults with LD and / or autism there is an Admissions Avoidance Register in place which is considered monthly, as part of a multi-agency approach
- a pilot has been put in place to provide a crisis service for adults with LD and / or autism – this is currently providing outreach support only but will include a place of safety from June 2019
- there is a regular Somerset LeDeR steering group that meets regularly to discuss the outcomes, recommendations and quality of local LeDeR reviews. This is chaired by our Clinical Lead GP for Learning Disabilities. The local area coordinator is Associate Director of Safety and Quality Improvement
- our Director of Quality and Nursing is chair of the SW regional LeDeR steering group
- our LeDeR Programme infrastructure is in place and the overall rate of completion within 6 months for the period February 2018 to date is 42%, the current rate of 56% shows improvement during this period
- the LD Partnership Board has been restarted and is underpinned by four Peer Support Groups in Yeovil, Frome, Taunton and Bridgwater
- a review has been undertaken of LD Registers and Annual Health Checks (AHCs) and an action plan has been developed for 2019/20 including a training plan for GPs and engagement with parents / carers. The LD Clinical Lead GP has created a video about the benefits of AHCs working with a Young Champion

3.13. Maternity and Children and Young People

Summary of Maternity and Children and Young People for 2017/18 to 2018/19:

- roll out of 'Better Births'

What we did in 2018/19:

- reduce the number of babies who are still born by 20% 2020
- reduce women smoking at the time of delivery to 10% by 2019

Better births action plan in place which includes delivery of:

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

3.14. Medicines Optimisation

Summary of Medicines Optimisation for 2017/18 to 2018/19:

Medicines account for 20% of the healthcare budget (medicines are the most common intervention in the NHS, with 48% of adults having taken a prescription medicine in the last week) and when used correctly are responsible for improving patients outcomes and both primary and secondary prevention. Virtually every patient with a condition such as stroke, diabetes, respiratory disease or mental health will, or should be, taking medication. These are all priority areas for the health service in Somerset to improve the health outcomes for patients and there is wide range of other long term conditions which Somerset's demographics and historical lifestyles are driving such as osteoporosis and osteoarthritis.

We have also sought to improve medicines optimisation by concentrating our efforts on:

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

- items not routinely prescribed and conditions for which over the counter (OTC) items should not be routinely prescribed in Primary Care: we have already achieved reduced levels of prescribing of low value items and OTC items more suitable for self care. We will continue to focus on these areas with prescribers to free up more resources. This area is included within the prescribing scorecard. Savings released form part of our prescribing savings plan

What we did in 2018/19:

We have an active medicines optimisation Strategy that supports prescribers to make evidence based, cost effective and safe prescribing decisions in conjunction with their patients.

Nationally there is an increased focus on medication safety and harms caused by polypharmacy, inappropriate monitoring and poor communication around medicines on movement across boundaries. Somerset CCG benchmarks well against these safety indicators showing the benefit of the medicines optimisation focus which has been facilitated by the medicines management team for many years.

The CCG Prescribing Scorecard has shown a significant improvement in the number of indicators which have been achieved during 2018-19.

Some of the notable achievements over the past year have been:

- the combined CCG commissioned Pharmacist Care Home service reviewed just under 3000 patients in 2018-19 and implemented annualised savings of £207,377 and made 1116 safety recommendations for the patients reviewed.
- through improved medicines optimisation Somerset CCG has achieved all of its national Anti-microbial stewardship targets.
- continued improvement on safety, quality and cost effectiveness of prescribing in Somerset
- supported practices in using the eclipse live tool to help reduce medicines related admissions
- increased the number of Care home patients who received a clinical pharmacist medication review
- showed significant improvements on the Somerset prescribing scorecard
- worked with acute trust colleagues to facilitate the early adoption of biosimilar medicines across Somerset
- implemented the innovative diabetes technology Freestyle libre by linking use to better diabetic disease outcomes
- championed deprescribing of medication of low value or where risk outweighs benefit eg. the stopping over medication of people with a learning disability, autism or both (STOMP) agenda and deprescribing of antipsychotics in Dementia patients
- worked to identify and address unmet need such as anti-coagulation in patients with AF

Despite these successes there remain a number of clinical areas where further improvements in medicines optimisation are required to help improve outcomes for patients and this will continue to the focus of the team in 2019-20.

3.15. Improving Quality

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

We are responsible for ensuring that the services we plan, buy and monitor (commission) in Somerset meet local needs and national standards around quality, safety and access (how long patients wait to be seen and treated). We make sure that we work within the guidance set out by NHS England, for example the priorities set out for us in the annual Planning Guidance, and the national standards set out in the NHS Constitution.

We see the improvement of quality and patient safety to be the organising principle of our health and care services. It is what matters most to people who use the services and it is what motivates and unites everyone working in health and care. Our key focus is to ensure that quality and patient safety is built into commissioning structures, values, practices and business processes through the annual cycle of clinical quality activity.

The quality and safety of NHS Somerset CCG commissioned health services are monitored through a range of mechanisms including the Clinical Quality Review Meetings (CQRMs) held with each provider on a regular basis. In addition to analysis of the scorecard quality indicators, a range of activities are undertaken on a day to day basis to gain intelligence on the quality of service provision, to identify any 'early warning' signs of service failures and to work with partner agencies towards sustainable quality improvements. We continue to listen to our patients and carers, and work with all our service providers to achieve continuous improvement and reduce variation in the quality of their services.

We will work closely with our commissioning colleagues to ensure new models of care in line with the 5 Year Forward View, the multi-year STP and the development of greater integrated health and care systems, have quality at their core.

What we did in 2018/19:

- We commissioned an independent review into emergent new workforce roles to support our focus on improving workforce retention and development.
- Improvement in discharge planning for patients following inpatient care and effective ward rounds
- Reduction in MRSA health care acquired infection - we continually strive to maintain reductions in C Difficile and E Coli (see section 3.16 for more detail)
- Supported a system wide review through the Safeguarding Adult Board of the care provided by the National Autistic Society at Mendip House within Somerset Court in Highbridge. The report has been published by the Somerset Safeguarding Adult Board (Somerset Safeguarding Adults Board Reviews)
- Reduced the backlog of pending Continuing Healthcare (CHC) applications from over 440 cases in April 2018 to 89 cases April 2019 with an expectation to achieve no people waiting more than 28 days by end of July 2019 (see section 3.17 for more detail)
- Strengthened the links between services for continuous quality improvement to join up a range of safety initiatives such as reducing risks of sepsis, pressure ulcers and falls
- Establish a clinical senate to balance the financial decision making across Somerset
- Continued to improve the way in which statutory services (health, local authority social care and education and police) to protect children from abuse and neglect through sharing information and actions
- The CCG has led a small number of key multi-agency reviews covering pathways of care arising from incidents and complaints. The findings of which have been influential on

areas of improvement work, such as the discharge arrangements, early diagnosis and treatment of sepsis and managing vulnerable adults. Of which one of these reviews which was commissioned as an independent external review (a copy of the report can be found on the CCG website - Pancreatitis Service Review.

3.16. Infection Prevention and Control

Infection Prevention and Control remains a key quality imperative for health and social care commissioners and providers. Good progress has been made in reducing some Health Care Associated Infections (HCAIs) but there is still more progress and constant vigilance needed to address infection risks from improvements and changes in healthcare provision and emerging infection threats. Such as:

- **Gram Negative Bloodstream infections** (GNBSIs) including *Escherichia coli* (*E.coli*). Rates of blood stream infections due to gram negative bacteria have been rising since national reporting of these infections began in 2011 and 2017. There is a national ambition to reduce these infections by 50% by 2023/24. Approximately 80% of these infections arise in the community, making prevention of infection as much of a community problem as a hospital one. The majority of all GNBSIs are found to have started from a urinary source and much work is being carried out to tackle this matter. During 2018/19 we have been over trajectory with a total of 515 cases against an end of year trajectory of 396.

At the same time many of the existing antimicrobial treatments that we have for bacteria, viruses and fungi are becoming less effective. When this is combined with very limited development of new antibiotics, there is a real risk that everyday infections or diseases will become untreatable, making prevention of spread of infection even more critical.

Tackling Antimicrobial Resistance (AMR). The UK's national action plan sets out to tackle AMR within and beyond our own borders and focuses on three key ways to tackling AMR:

- reducing need for, and unintentional exposure to, antimicrobials
- optimising use of antimicrobials
- investing in innovation, supply and access

Clostridium *difficile* (C.*diff*)

We are under trajectory for C diff cases with a total of 77 cases in 2018/19 to date against a target of no more than 130 cases.

MRSA

Zero tolerance approach. There has been a total of 12 MRSA BSIs in 2018/19 to date, of which 4 were acute trust onset. A post infection review took place on each case to identify why the infection occurred and how future cases can be avoided.

Our healthcare providers have well developed structures and processes in place and this provides a good basis from which to develop a county-wide approach that is fully inclusive of primary, community, social and home care settings. The challenge is to ensure investigation and rapid learning from an increased number of infection incidents, ensuring this is translated into consistent knowledge and practice in care homes, social care and further community settings.

3.17. Continuing Health Care

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

NHS Somerset holds the statutory responsibility to deliver the CHC process aligned to the principles of NHS National Framework for Continuing Healthcare and NHS-funded Nursing Care 2016 and now 2018 (revised). From early 2017 the key priority for CHC was to develop a team fit for purpose that could deliver on these principles and that was able to work effectively with system partners. To inform service development the team needed to develop accurate reporting capacity on key performance areas reflected in the quality premiums set by NHS England of:

- less than 15% of all assessments to take place in acute settings and 80% of all decisions to be made within 28 days of notification to the CCG

The CHC team have undergone significant investment to support transformational change during this period. An overarching priority for the team was to foster and develop a positive partnership culture with Somerset County Council (SCC) to deliver our respective responsibilities. Investment allowed the team to develop a service and delivery model in partnership with SCC that has promoted and embedded quality, efficiency and consistency in practice.

What we did in 2018/19:

- commissioned and embedded a new CHC specific data platform “Caretrack” to support the management of patient records and reporting capacity around Key Performance Indicators
- continued to invest in the team in the team to enhance assessment, quality of supporting evidence, safeguarding, data management and analysis, service improvement, contracts, commissioning and local resolution functions
- undergone a service wide restructure to support better alignment for deliver on the principles of the national framework
- worked in partnership with SCC to agree a joint position on interagency operational pathways and dispute resolution
- developed and agreed the content with SCC on the training content for undertaking CHC processes
- established strategic multiagency steering group with system partners to support joint working and effective practice in CHC
- embedded quality in practice through routine assurance reviews on applications
- worked systematically to reduce the waiting list of over 450 patients awaiting CHC assessments following the in-housing of the assessment teams
- work toward attainment of the quality premium target of 28 day from checklist to eligibility decision
- delivered the quality premium requirement to assess patients for CHC outside of the acute hospitals in the community setting where their needs are better understood
- progressed the outstanding reviews of care needs and where appropriate, eligibility, for patients who have been in receipt of CHC
- delivered on Quality Innovation Productivity and Prevention of £6.3m with an initial target of £5m, an additional stretch of £1m and an overachievement of £0.3m
- undertaken a deep dive and service redesign of the personal health budget (PHB) offer and pathway to support meaningful personalised commissioning
- revised PHB Policy and PHB Agreement

- offered PHB to all newly eligible patients living in their own home (excludes fast track) as mandated by NHS England
- identified and commissioned a PHB virtual banking and market place platform to be piloted for PHB holders to better support fiscal governance and market access for budget holders
- reviewed and revised the Fast Track documentation in consultation with system partners to support greater clinical governance in respect of end of life commissioning
- commenced discussion with SCC to support an agreed position on the use of self-employed care workers and the development of an integrated commissioning position
- provided training to the health and social care sector on CHC
- supported independent review of CHC eligibility decisions for NHS England
- supported staff resilience through bespoke development and coaching

3.18. Enablers – Workforce

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

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

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

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

What we did in 2018/19:

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

3.19. Enablers - Digitally enabled transformation

Summary of key priorities for digitally enabled transformation for 2018/19 to 2019/20:

To digitally support the Fit For My Future Health and Care Strategy including:

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

Establishing services to better support patient flow across the Somerset community & wider South West

What we did in 2018/19:

- developed a Somerset Business Intelligence Strategy with four workstreams:
  - analyst skills and system solving
  - population intelligence
  - live system control
  - data integration, data quality and routine reporting
- linked the Somerset Business Intelligence Strategy to the Joint Strategic Needs Assessment for data integration
- delivered Estates and Technology Transformation funded schemes: Extended Access, One Domain and SIDeR (see below):
  - successfully contracted with a Technology Partner, Black Pear Software Ltd
  - created an Information Sharing Agreement to underpin proposed services
  - spine mini services enabled to establish NHS number as primary key
  - formed clinical, information governance and technical working groups
  - completed preparations for go live with new End of Life service on 1 April
  - launched a service to monitor bed occupancy across all nursing care homes
- digital support to UEC Programme including participation in procurement of a new 111/OOH provider, 111 Online, Direct Booking and Bed Management
- supported an Artificial Intelligence pilot in a GP Practice
- GP Online Consultations (Repeat prescriptions, appointments, Detailed Coded Record Access – extended use by patients across Somerset)
- enabled patient wi-fi access across all Somerset GP Practices
- EMIS Viewer – increased use in all settings including Community Pharmacies, capturing benefits and providing feedback assurance to GPs
- support further range of clinically led initiatives emerging through the Clinical Health and Care Strategy
- established a process for sharing safeguarding information on vulnerable children across all Somerset providers
- supported launch of a digital diabetes management system that has been recognised with nationally
- maintained core GP IT infrastructure, all GP Practices using one system
- created and launched 2 week wait e-templates for GPs
- raising awareness and information of digital enabling support and supported initiatives via Your Somerset, social media and patient / professional briefing sessions including PPG digital lay user group and public health sessions
- exploring EMIS Health Analytics and potential of data analysis to support GPs
- supported funding for new electronic Child Death Overview Panel system

3.20. Enablers – Estates

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

- Benchmark estates and develop an estates strategy for Somerset

What we did in 2018/19:

- the STP estates strategy provides a strategic, system wide review of the estate within Somerset. The demand for urgent and emergency care has been growing consistently over the last few years. For example: in the last three years the number of people attending Emergency Departments has risen by 5.5% and at minor injuries units by 2.3%. We should expect this demand increase to continue; the population is growing, and particularly in the older age groups who are most likely to need urgent care. The overarching aim of the estates strategy is to develop a modern estate that can support the delivery of new service models that can meet this demand. The key priorities in the strategy are to first develop our acute estate so that these facilities can help to meet demand and where appropriate shift activity out to community services. The supporting priorities set out in the STP Estates Strategy are to develop the estate around community and primary care sites to accommodate the new models of care and also ensure that supporting strategies such as digitalisation and workforce are appropriately funded and delivered. Whilst there is a need to improve primary and community estate it is in relatively good condition in comparison with the acute estate. Therefore, investment is primarily focused on the acute estate

- the STP has come together to develop a common understanding of the key priorities and the capital bidding process has been supported by using a capital bidding template that have each been assessed, prioritised and signed off by the Partnership Executive Group (PEG) of the STP. This will continue to be the governance process for the ongoing delivery of the STP Estates Strategy. The STP Estates Strategy was assessed with a ‘Good’ Rating in November 2018 and will be further refreshed during 2019/20

- the number one priority for Somerset STP is the re-provision of new theatre and critical care facilities on the Musgrove Park Hospital site. The existing facilities are provided from outdated buildings that require investment in order to provide compliant premises. Taunton and Somerset Trust were successful in obtaining funding of £79.5m through the Wave 3 STP capital bidding process and the Outline Business Case has been approved by NHSI/DHSC. In addition Musgrove Park were successful in the wave 4 STP capital bidding with a proposal to centralise acute assessment and ambulatory care services on the Musgrove Park Hospital Site (£11.5m). This scheme has been prioritised as it is not subject to the Health and Care Strategy outcome and consultation. Furthermore, the scheme supports delivery of recurrent savings across the STP

3.21. Enablers – Developing the Somerset Sustainability and Transformation Plan

Somerset CCG has been working with its system partners over the previous year to move towards an Integrated Care System for Somerset, which will be delivered in the future, with the partners working together to develop this over the next year. 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. This will include working closer with the other commissioners of health and care in Somerset (NHS England and Somerset County Council). During the year Somerset CCG has been preparing to take on the delegation of primary care commissioning.

To deliver the 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 partners have agreed to a single programme of in-year improvement and delivery, strategic direction, and transformation change, which will continue into 2019/20.

The Somerset Health and Care Strategy demonstrates the case for change within Somerset and we know services in the county are not keeping pace with the changing needs of local people and it is becoming increasingly difficult to ensure access to consistently high quality care that is affordable and sustainable. During 2018/19 a number of strategic outcomes were agreed that do not require public consultation and these will be delivery into 2019/20.

The system partners have reconfirmed the Somerset ambition for modern health and care services in Somerset;

- People to live healthy and independent lives, supported by thriving and connected communities with timely and easy access to high-quality and efficient public services when they need them

We know changes will be more effective if we focus on a small number of things each year, concentrating our efforts on actions that will have the greatest impact so together we have agreed five priority areas of focus for health and care that we will work on to begin to change how we deliver by April 2020:

Prevention

We want to invest more to help people stop getting ill in the first place; focussing on:

- development of social prescribing
- prevention of cardiovascular disease

Development of local services

- development of neighbourhood integrated teams across Somerset, supporting people at home rather than in hospital

Strengthening more specialist and acute services

- design the model for acute service provision that ensures both hospitals have a vibrant future and distinct purpose with stronger links with other hospitals outside of Somerset
- increase the capacity in the primary and community-based adult mental health services and continue the development of home treatment services to provide an alternative to mental health inpatient admission and support discharge from hospital
- review a new model for the provision of earlier intervention services for children in crisis

Developing an Integrated Care System

- work together to develop systems that support information sharing, joint decision making, service integration and rebalancing resource allocation towards prevention and place-based care

Improving our financial position

- develop and start delivering a sustainable financial recovery plan

As part of the developing and continued working towards a single system on finances, activity and workforce the individual operational plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership, including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery, in 2018/19 and forwards from here. 2018/19 was the first year of a 3 year Memorandum of Understanding that has moved the NHS away from an income/payment by results model, towards a focus on the total cost basis for delivery of health and care.

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

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

During the refresh of 2019/20 plans the Somerset STP leadership has jointly worked through (with the wider clinical and executive teams) the assumptions and plans for the future, including the agreement of standards and levels of care that are expected to be delivered, and the trajectory for sustainable delivery of these access standards within the financial envelope.

3.22. Sustainable Development

Somerset CCG adopted the Sustainable Development and Carbon Reduction Strategy and its associated plans that were put in place by Somerset Primary Care Trust and we have 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.

We have continued to support its commitments as a socially responsible employer. This includes initiatives to:

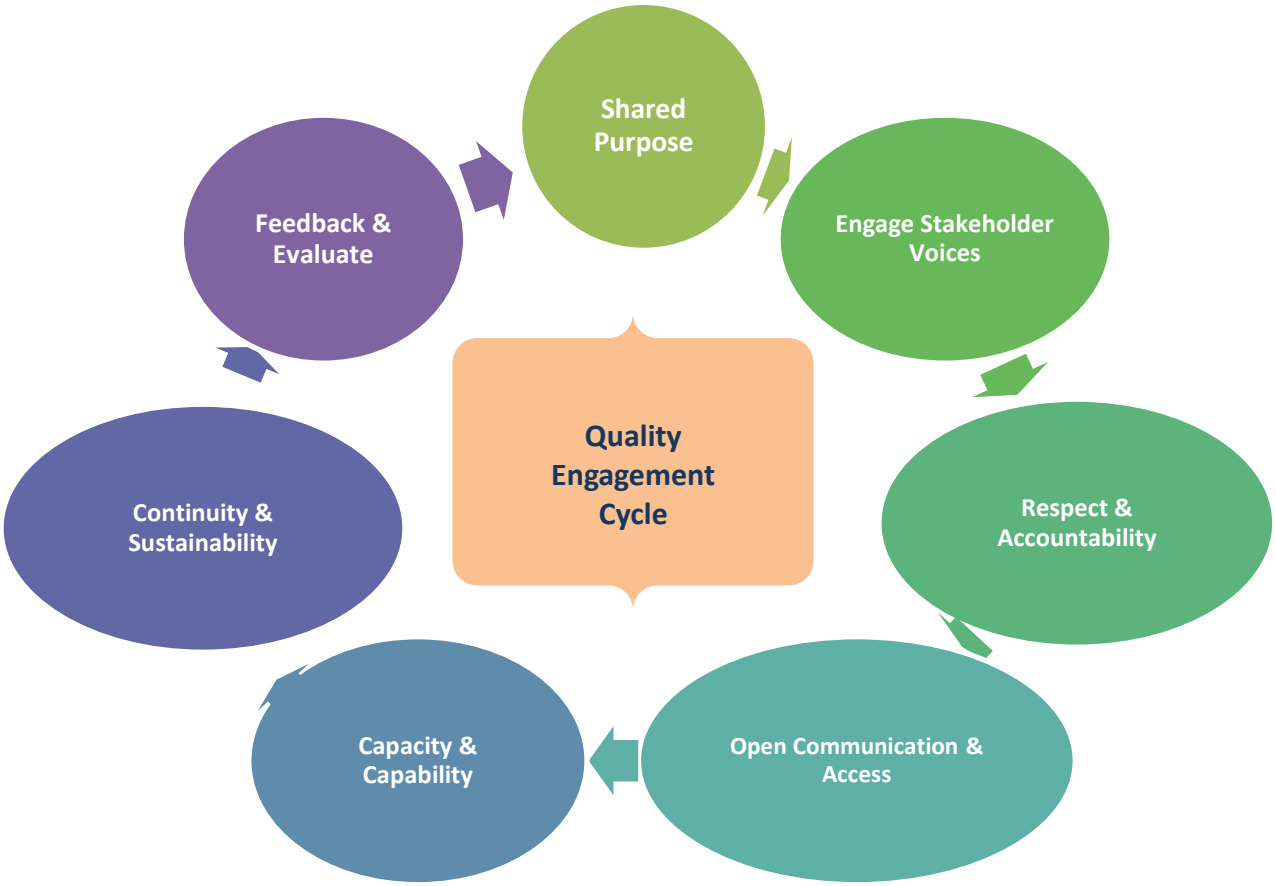
- support the cycle to work scheme which also helps to improve the health and well-being of staff
- help the national NHS target of reducing carbon emissions through employee travel
- work with the waste management service provider to increase the amount of recycled materials
- reduce the use of printers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

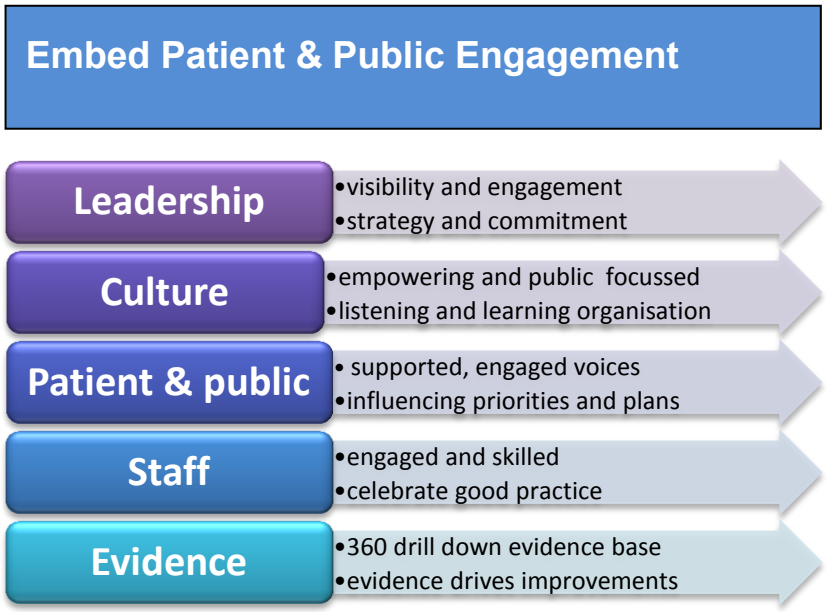
3.23. Engaging people and communities

As part of our ongoing organisational strengthening, we have set in motion plans to fully embed patient and public participation in commissioning processes, enabling people to voice their views, needs, contribute to plans, proposals and decisions about health services in their locality. We are building on our existing foundations to establish a patient/public strategy driven by leadership, embraced by our organisational culture and implemented by staff who are inspired about involving patient voices in their day to day work. To do this we are working to:

- improve visibility of engagement at Governing Body meetings
- produce a new Public Participation and Engagement strategy
- develop existing groups such as SEAG and PPGs to facilitate effective change
- innovate new models and methods to involve/engage with patients and the public
- build public engagement early into our planning cycles
- look for opportunities to partner with existing neighbourhood networks
- train the Governing Body and leadership in engagement best practice
- hold meetings that are fully accessible and reach seldom heard groups
- build engagement activities that influence and drive commissioning priorities
- demonstrate public involvement in annual reports
- to set up a Lay Users Forum to provide better support, coordination and governance of Lay User involvement

Our approach to quality engagement is set out in the diagrams below:





To ensure staff are passionate and confident to involve patients and the public we are working to equip them with skills so their commitment to engage is core in day to day work.

We will champion a Quality Engagement Cycle and support learning through the following:

- provide training to programme leads/staff to ensure pathways and services are designed to include patient and public engagement at the outset
- promote honesty and transparency, and evidence based decisions
- ensure patient voices are heard and able to influence at meaningful stages
- invest in growing engagement partnerships and build ongoing dialogues
- review experience, positive and negative, learn from it and continuously improve

- value lived experience and use the strengths and talents people bring
- acknowledge and celebrate contributions, show how involvement has influenced change
- support to patients/the public to hold commissioners and providers to account on engagement and consultation duties

Complaints

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

During 2018/19 Somerset CCG received 81 formal complaints. Of these, 76 were closed. The main themes arising from these complaints were:

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

Learning from complaints has been used to inform commissioning decisions and improve processes during 2018/19. Examples include the procurement of a new integrated urgent care service for Somerset and the CHC team introducing new processes to improve patient experience.

Further detail on complaints will be available in the Annual Complaints Report which will be published on the Somerset CCG website during the summer.

3.24. Health and Wellbeing Strategy

Health and Wellbeing Board

The CCG is an active member of the Health and Wellbeing Board which was comprised of the following membership at 31 March 2019:

Member	Organisation
Cllr Christine Lawrence (Chair)	Somerset County Council (SCC)
Cllr Frances Nicholson (Vice Chair)	SCC
Cllr David Huxtable	SCC
Cllr Linda Vijeh	SCC
Cllr Amanda Broom	SCC
Cllr Jane Warmington	Taunton Deane Borough Council
Cllr Sylvia Seal	South Somerset District Council
Cllr Gill Slocombe	Sedgemoor District Council
Cllr Keith Turner	West Somerset District Council
Cllr Nigel Woollcombe-Adams	Mendip District Council
Dr Ed Ford (Vice Chair)	Somerset CCG
Maria Heard	Somerset CCG
David Freeman	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
Supt Mike Prior	Chair, Safer Somerset Partnership

The overall aim of the Health and Wellbeing Board is that it will provide strategic leadership to improve the health and wellbeing of the residents of Somerset through the development of improved and integrated health, public health and adults and children's social care services.

In particular, the Board:

- oversee, where appropriate, the use of resources across a wide spectrum of services and interventions, to ensure that the SHWBS and priority outcomes are achieved and, to drive a genuinely collaborative approach to commissioning, including the co-ordination of agreed joint strategies
- support the inclusion of the public, patients and communities in the setting of strategic priorities, including (but not solely) through the involvement of local Healthwatch
- communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their own health and wellbeing and that of the people living around them

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 2018/19 the 4 key workstreams have been:

- to provide joint leadership for prevention across the county

- to support the drive for improved joint working with Health at strategic and operational level
- to give system leadership to building stronger, resilient, healthy communities
- to provide system leadership to address multiple vulnerabilities and complex needs

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.

By combining the Health & Wellbeing Strategy ('Improving Lives') and the health and care services strategy ('Fit for my Future'), the CCG has been able to increasingly join up our ways of working, our resources and our long term transformation plans. To support this, in 2018/19 we developed a joint three-year financial recovery plan which drew together our ambitions for clinically and financially sustainable health and care in Somerset.

The plans have informed the development of our joint approach for Somerset in 2019/20 which focus on managing demand and reducing cost across the system.

In partnership with others, one of the CCG's key priorities in 2019/20 is to reduce unwarranted variation across our county. We are using national data and benchmarking (in the form of nationally published data packs (such as Rightcare, Getting It Right First Time, Model Hospital and Best Practice Reference Costs) to look at elective and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care. We are also planning a system-wide approach to the efficient and cost effective use of bed capacity across all STP Partners.

Reducing health inequality

Health inequalities are differences in health between people or groups of people that may be considered unfair, reflect historic and present day social inequalities in our population. Reducing inequalities should allow everyone to have the same opportunities to lead a healthy life. In Somerset we have as a health system committed to implementing Quality Equality Impact assessment (QEIA) methodology for all cost improvements, service development redesign/changes flag any potential impact on people or groups. This approach will underpin system planning and working across Somerset.

3.25. Emergency Planning

All NHS organisations work together 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.

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 we have been an active member of both the executive and tactical steering groups. We have worked in partnership with NHS England during 2018/19 to ensure there was a coordinated response to escalation pressures and emergency planning by health services in Somerset. In addition, organisations across Somerset work closely together to ensure that plans are as integrated and effective as possible.

Our CCG has emergency response plans in place, which are fully compliant with the NHS England Emergency Preparedness, Resilience and Response Framework 2015. We regularly reviews and makes improvements to our incident response and business continuity plans and there is a programme in place for regularly testing these plans, the results of which are reported to the Clinical Executive Committee and Governing Body. We carried out our annual self-assessment assurance process with NHS England to assess our plans and procedures and together we and NHS England met with our three key providers to review their plans. We were assessed as being fully compliant with the standards and the three providers were assessed as being substantially compliant.

Somerset responded to a severe weather major incident in March 2018 as a result of heavy snowfall across the county and again managed a critical incident related to snow in January 2019. All the partner organisations cooperated effectively to maintain services and implemented their respective emergency plans. Learning from the events in March 2018 was used to inform the review of plans and this helped to improve the readiness for the incidents this winter. The learning from the latest incident will be shared and implemented during 2019 as part of the ongoing testing and exercising of plans.

3.26. Risk Management

Our 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 our strategy, achievement of our objectives and the management of our relationships with key partners.

We are 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

Our strategic risks form an integral part of the Governing Body Assurance Framework (GBAF) which is reviewed regularly. The latest version of the GBAF can be found by visiting the CCG's website and the pages for the Governing Body meetings. In 2018/19 we implemented the results of our governance review, which included revising the committee structure and the GBAF. There is also more detailed analysis of the key risks set out in the Governance Statement later in this report.

Key risks managed by us during this financial year have included:

- Ambulance service response times
- Adult and children's mental health services
- financial budget overspends due to under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings targets, overspends against activity related contracts and national increases in drug tariffs
- Cyber-security
- access to services waiting times, including waits in A&E and from referral to treatment
- the quality and safety of some services identified through CCG quality monitoring systems and / or through CQC regulatory inspections. In 2017/18 this was a particular concern for the 111 and Out of Hours GP Primary care service provided by Vocare in Somerset
- future sustainability of services at Weston Area Health NHS Trust
- workforce sustainability
- the delivery of the STP Health and Care Services Review 'Fit for My Future'
- managing the potential risks relating to a no deal EU Exit

4. Financial and Performance Analysis

4.1. Finances

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 2018/19' issued by the Department of Health. The financial information included in this section of the Annual Report is taken from the 2018/19 financial statements.

Operating and Financial Performance

4.2. Financial Duties

During 2018/19, our performance against our financial duties is shown in the table below:

2018/19 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	✓

Specific details of each of these duties are provided below.

4.3. Overview

For the financial year 2018/19 (1 April 2018 to 31 March 2019), we delivered all of our financial targets and delivered a breakeven position against our in year revenue resource limit of £761,787,000.

4.4. Analysis of Revenue Performance

	2018/19 £'000
In Year Revenue resource limit	761,787
Variance against revenue resource limit	0
Percentage variance against revenue resource limit	0.00%

We planned to deliver a deficit of £9,000,000 for 2018/19 against the portfolio of the services we commission, as agreed with NHS England. The CCG was eligible to receive £9,000,000 Commissioner Sustainability Funding (CSF) in year, subject to a review by NHS England against achievement of the financial plan and adherence to the conditions of the CSF. We have demonstrated achievement of the CSF conditions for 2018/19 and have therefore been confirmed as eligible to receive the full funding available, therefore enabling the CCG to deliver a balanced position for 2018/19.

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

The Finance and Performance Committee continues to meet on a monthly basis to review the financial position and identify mitigating actions to ensure we deliver our financial plan.

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

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

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

A full set of the Somerset CCG's Annual Accounts for 2018/19 are included at Appendix 1 to this report and describe how we have used our resources to deliver health services to residents of Somerset during 2018/19. An explanation of the key financial terms can be found within Appendix 1, alongside the Annual Accounts.

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

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

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

Going Concern

4.5. Introduction

The annual accounts of the CCG are prepared on the basis that the organisation is a ‘going concern’ and that there is no reason why it should not continue in operation on the same basis for the foreseeable future.

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

The Department of Health Group Accounting Manual for 2018/19 has the following recommendation as the standard accounting policy:

> The CCG’s accounts have been prepared on a going concern basis. The Government Financial Reporting Manual (FReM) notes that in applying paragraphs 25 to 26 of International Accounting Standard (IAS) 1, preparers of financial statements should be aware of the following interpretations of Going Concern for the public sector context:
>
> - for non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern. Department of Health and Social Care (DHSC) group bodies must therefore prepare their accounts on a going concern basis unless informed by the relevant national body or DHSC sponsor of the intention for dissolution without transfer of services or function to another entity. A trading entity needs to consider whether it is appropriate to continue to prepare its financial statements on a going concern basis where it is being, or is likely to be, wound up
>
> - sponsored entities whose statements of financial position show total net liabilities must prepare their financial statements on the going concern basis unless, after discussion with their sponsor division or relevant national body, the going concern basis is deemed inappropriate
>
> - where an entity ceases to exist, it must consider whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern in its final set of financial statements
>
> - where a DHSC group body is aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the entity, these uncertainties must be disclosed. This may include for example where continuing operational stability depends on finance or income that has not yet been approved

4.6. Criteria

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.

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.

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.

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

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

Financial Assumptions for 2018/19

4.7. Outturn

The financial outturn for 2018/19 is a balanced position against the £9m deficit control total agreed with NHS England. The CCG was eligible to receive £9m Commissioner Sustainability Funding (CSF) in year, subject to a review by NHS England against achievement of the financial plan and adherence to the conditions of the CSF. We have demonstrated achievement of the CSF conditions for 2018/19 and have therefore been confirmed as eligible to receive the full funding available. This has enabled us to deliver a final break even position against our revenue resource allocation for 2018/19. 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.

4.8. Cash Flow

The cash position is reported on a monthly basis to the Finance and Performance Committee and 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 2018/19 and is planning to do so on an ongoing basis.

4.9. Contingent Liabilities

The CCG has contingent liabilities in 2018/19 relating to:

- Continuing Healthcare cases – to reflect a risk associated with the provisions estimate made for pending continuing healthcare eligibility assessments
- pending legal claims
- a staff redundancy claim

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.

4.10. Services

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. We are not aware of any plans that would fundamentally affect the services provided to an extent that the organisation would not continue to be a going concern.

4.11. Interim Operational Financial Plan 2019/20

The CCG Governing Body approved an updated interim Operational plan for 2019/20 at its meeting on 23 May 2019.

The interim CCG plan is in line with the CCG business rules to deliver the deficit control total of £4.5m set for 2019/20. This deficit control total will be matched with £4.5m available Commissioner Sustainability Funding (CSF) to enable the CCG to deliver a break-even position for 2019/20. The Somerset system is working together to deliver a joint Financial Recovery Plan including both commissioner QIPP and provider CIP to ensure that the system is focused on real system cost reductions in 2019/20 to support the position.

The CCG has based its interim plan for 2019/20 on a published notified allocation of £865.3m. This allocation includes the following:

- baseline funding including growth - £771.9m
- recurrent funding adjustments from 2018/19 - £0.9m
- funding for primary care medical services, previously commissioned directly by NHS England, for which the CCG will take on full delegation of commissioning responsibility in 2019/20 - £75.9m
- running cost allocation - £11.8m
- Identification Rules Adjustment - £0.6m
- Primary Care Improving Access Funding - £3.3m
- Paramedic Rebanding (non-recurrent) - £0.7m
- Ambulance Winter Funding (non-recurrent) - £0.2m

Although the interim budgets contain a significant financial challenge to deliver the control total as set by NHS England, the CCG needs to ensure that through actions agreed with partners across the Somerset system and delivered through the Somerset Sustainability Transformation Partnership, the CCG will not breach its 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

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.

The financial plans for 2019/20 have been based on a number of planning assumptions, which have in turn been taken from national planning guidance and local decisions.

Within the national shared planning guidance, CCGs are required to support the ambition to achieve genuine parity of esteem between mental and physical health services. This includes an expectation that our spending on Mental Health would increase in real terms by 6.5% in 2019/20. For Somerset this requires additional investment of £5.4m. The interim plan achieves the Mental Health Investment Standard in 2019/20. Discussions are ongoing across the Somerset system as to how mental health investment funding should be most appropriately deployed.

The coming year is going to be pivotal in making progress against financial turnaround plans. Getting the right plans, delivering in the right ways and at pace is vital in order to deliver the system financial position across all partners. The Somerset system is committed to the continued refinement and improvement of these plans to ensure delivery of the financial position through the shift we need to see in Somerset health and care services.

4.12. Planning Assumptions

The 2019/20 financial plan is based on the application of national tariff prices for 2019/20 as issued in January 2019.

Acute growth is set at locally agreed growth rates. Non-elective growth has been assumed at 3.2% and is anticipated to be fully mitigated by QIPP schemes invested in and implemented by the A&E Delivery Board. Elective growth has been assumed at 4.1%. Growth on mental health and community contracts has been included as investment rather than growth, along with additional mental health investment required in order to deliver the Mental Health Investment Standard.

4.13. Quality, Innovation, Productivity and Prevention (QIPP) Schemes

We have developed an efficiency programme which focuses on new schemes for 2019/20. The table below shows the anticipated efficiency savings from these programmes.

2019/20 schemes	Anticipated Efficiency Saving £'000
GP Prescribing	1,275
Continuing Healthcare	1,754
Demand Management	5,206
Community Services	2,935
Other Schemes	738
Unidentified Schemes	2,385
Corporate Services Review	1,600
Acute Services Review	4,200
Primary Care	200
High Cost Drugs	1,497
Independent Sector Providers	1,000
Total QIPP	**22,790**

4.14. Recommendation

Having considered the going concern guidelines, the financial reporting and governance arrangements of the CCG, delivery of the 2018/19 financial position and plans for 2019/20 as set out above, it is recommended that management prepare the annual accounts for 2018/19 on a going concern basis.

4.15. Revenue Resource Limit

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

Revenue expenditure covers general day to day running costs and other areas of ongoing expenditure. The CCG met its statutory duty to operate within its revenue resource limit for 2018/19.

The CCG's performance for 2018/19 is as follows:

	2018/19 £'000
Total net operating cost for the financial year	761,787
Final in year revenue resource limit for the year	761,787
Under/(over) spend against revenue resource limit	**0**

This table highlights that in 2018/19 we broke even against our revenue resource limit.

4.16. Better Payment Practice Code

The 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.

Our performance for the year ended 31 March 2019 is summarised below:

Measure of compliance	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	**9,794**	**129,156**	**12,272**	**124,745**
Total Non-NHS Trade Invoices paid within target	**9,754**	**128,637**	**12,248**	**124,265**
Percentage of Non-NHS Trade invoices paid within target	**99.59%**	**99.60%**	**99.80%**	**99.62%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**3,406**	**538,557**	**3,396**	**512,129**
Total NHS Trade Invoices Paid within target	**3,401**	**538,171**	**3,387**	**511,760**
Percentage of NHS Trade Invoices paid within target	**99.85%**	**99.93%**	**99.73%**	**99.93%**

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

4.17. Cash Limit

The CCG is required not to exceed the cash limit set by NHS England, which sets the amount of cash drawings that the CCG can make in the financial year. The CCG drew cash totalling £760.248m (99.8%) against a cash limit of £761.720m, therefore meeting this requirement.

4.18. Running Costs

The CCG was funded a total of £11.95 million in 2018/19, equating to £19.27 per head of population, to support headquarters and administration costs. To support the effective running of the organisation the CCG has reviewed those functions which it provides in house and those which are provided by South, Central and West Commissioning Support Unit. The value of services commissioned via the South, Central and West Commissioning Support Unit is £4,561,792 which covers Business Intelligence support, Information Technology support, Procurement Services support, Booking and Referral Management Services, GP IT Services and additional consultancy support. Expenditure recorded against running costs for 2018/19 totalled £10.724 million.

4.19. Accounting Policies

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

4.20. Governing Body and Clinical Executive Committee Members

Full details of the remuneration paid to Governing Body and Clinical Executive Committee members and senior employees, which are included within the above management costs, are provided within the Remuneration and Staff Report at sections 8 and 9 to this report, together with their pension entitlements and declarations of interest.

4.21. External Audit

Grant Thornton UK LLP is the appointed external auditor for the CCG. The total fee paid to Grant Thornton UK LLP in 2018/19 was £63,000 including VAT to cover the cost of the statutory audit and associated services.

4.22. Governance Statement

The Chief Officer, as Accountable Officer, publishes an Annual Governance Statement, confirming the systems for managing risk within the 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.

A copy of the full Governance Statement is included in section 7 of this Annual Report and is also available on request or can be viewed on the CCG's website at:

www.somersetccg.nhs.uk

PERFORMANCE

4.23. Performance Summary

NHS England assesses the CCG's performance against the CCG Improvement and Assurance Framework on an ongoing basis, resulting in an overall performance rating at the end of the year. There are four domains to the framework with four rating categories: outstanding, good, requires improvement and inadequate. In 2017/18 our CCG was assessed as requires improvement.

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

2018/19 was a challenging year as a result of the increase in emergency demand with some Providers within Somerset struggling to 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.

Performance against the Referral to Treatment (RTT) local operating framework Incomplete Pathway trajectory, which was set lower than the national 92% incomplete pathway standard, has not been delivered on a cumulative basis during 2018/19. The number of patients waiting for their first definitive treatment has increased by 4,342 patients since March 2018 and is underpinned by an 18.8% increase in 2 week wait cancer referrals. From August 2018 Taunton and Somerset NHS Foundation Trust fell behind their improvement trajectory and Yeovil District Hospital NHS Foundation Trust fell behind the 92% national standard.

Performance against the 6 week diagnostic waiting times standard deteriorated during the first 6 months of 2018/19 although the number of patients breaching the standard reduced in Quarter 4. This has resulted in cumulative performance of 86.1% of patients waiting less than six weeks for their diagnostic test or procedure against the 99% standard and deterioration upon the previous year. This is underpinned by an increase in MRI, Echocardiography and Endoscopy breaches at Taunton and Somerset NHS Foundation Trust.

The CCG achieved three of the nine cancer standards in 2018/19, under achieving the 2 week suspected cancer and breast symptoms standards, the 31 day first treatment for surgery and 62 day waiting time cancer standards.

4.24. Performance Analysis

The CCG 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.

As part of the 5 Year Forward View a Sustainability and Transformation Fund 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 during

2018/19 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).

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

The performance delivered in respect of emergency and urgent care during the reporting period 1 April 2018 to 31 March 2019, for Somerset residents is set out below:

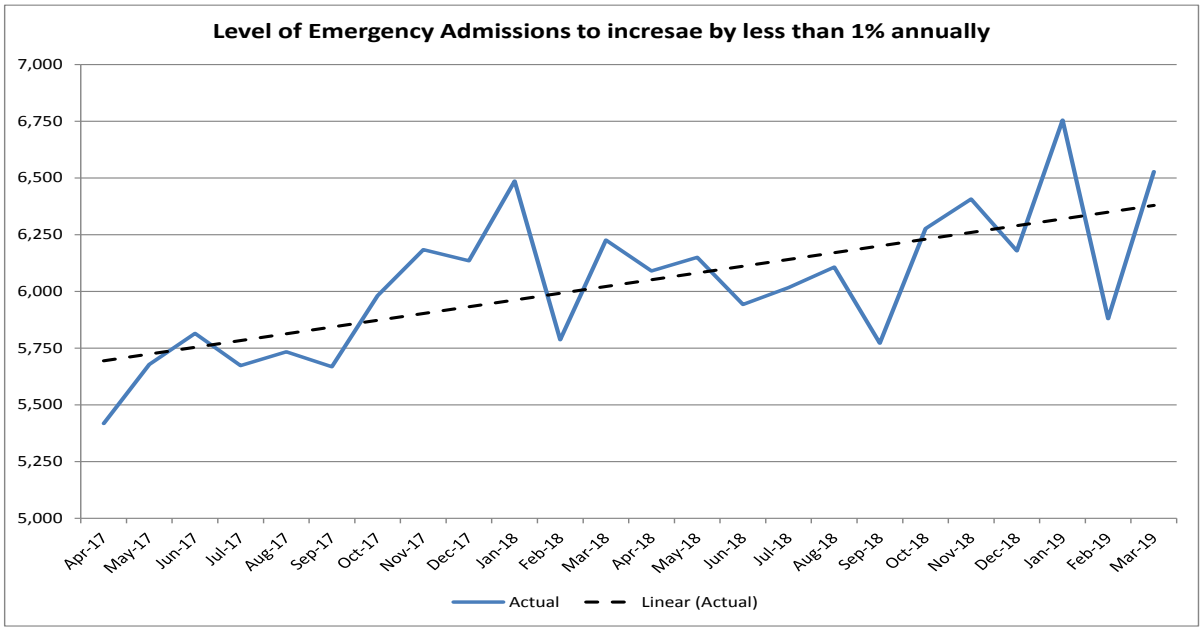
4.25. Emergency and Urgent Care Performance Scorecard between 1 April 2018 and 31 March 2019

Emergency Care	Standard	YTD 18/19	Variance +/(-)
Cumulative percentage of Trustwide MPH & YDH patients spending no more than four hours in A&E from arrival to admission, transfer or discharge	95%	92.47%	(2.53%)
Cumulative percentage of Somerset CCG patients spending no more than four hours in A&E from arrival to admission, transfer or discharge (inclusive of MIU activity)	95%	94.00%	(1.00%)
Cumulative number of MPH & YDH patients spending greater than twelve hours in A&E from decision to admit to admission	0	0	0
Percentage of ambulance handovers to A&E department within 30 minutes	100%	96.40%	(3.60%)
Percentage of ambulance handovers to A&E department occurring between 30-60 minutes	0%	3.41%	3.41%
Percentage of ambulance handovers to A&E department over 60 minutes	0%	0.18%	0.18%
Emergency admissions not to exceed planned levels	2.2%	4.69%	2.49%
Operations cancelled at the last minute offered another admission date within 28 days	100%	90.31%	(9.69%)
Percentage of people admitted to a stroke unit within 4 hours of hospital arrival	80%	64.04%	(15.96%)

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 2018/19. Whilst Yeovil District Hospital has consistently been ranked as one of the top 5 highest performing Acute Trusts nationally during 2018/19 despite seeing a 10.7% increase in attendance, the performance at Taunton and Somerset NHS Foundation Trust has been more challenged. Taunton and Somerset NHS Foundation Trust has experienced a 6.6% increase in attendance (with increases in demand particularly during the out of hours period) which has had an impact upon patient flow and resulted in a decline in 4 hour performance; alongside this Trust also seen a comparable increase the in the number of ambulance arrivals to A&E. However despite the decline in A&E four hour performance, specifically over the winter period, there has been an improvement in ambulance handover performance with 96.4% of patients being handed over to the care of the hospital within 30 minutes.

The number of emergency admissions has increased by 4.7% during 2018/19. This equates to 3,319 additional admissions and is comparable to level of growth observed in the previous year with all local Providers experiencing an increase in demand. Taunton and Somerset NHS Foundation Trust is experiencing a greater level of growth within the greater than one day patient cohort whereas the most significant area of growth at Yeovil District Hospital NHS

Foundation Trust is within the zero length of stay patient cohort which is attributed to the expansion of the Ambulatory Emergency Service and the South Somerset Symphony service.



The A&E Delivery Board has agreed priority schemes to fully mitigate the increase in demand observed during 2018/19 which focus upon reducing avoidable A&E attendances and admissions from A&E, as well as releasing bed capacity and improving patient outcomes.

Ambulance Response Times

4.26. Percentage of Category A calls receiving a response from South Western Ambulance Service NHS Foundation Trust for the period 1 April to 31 March 2019

Standard	Target	Trust-wide Performance	Performance in Somerset
Category 1 response - mean	7 mins	7.2	7.6
Category 1 response - 90th percentile	15 mins	13.3	14.4
Category 2 response - mean	18 mins	27.3	29.7
Category 2 response - 90th percentile	40 mins	57.6	61.4

The way South Western Ambulance Service NHS Foundation Trust are measuring their Category 1 response times changed on 23 November 2017 in line with the new national Ambulance Response Programme (ARP) standards. These new ARP standards were introduced in order to improve response times to critically ill patients through more appropriate use of triage time.

During the period April 2018 to March 2019 on a cumulative basis the mean Category 1 (life threatening calls) performance was 7.6 minutes against the 7 minute national standard compared against Trust-wide performance of 7.2 minutes and represents a significant improvement upon the previous year.

4.27. Waiting Times for Cancer Treatment

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

The performance scorecard in respect of the cancer waiting times standards achieved for services and Somerset patients, for the period 1 April 2018 to 31 March 2019 is shown below.

Waiting Times Standard	Standard	YTD 18/19	Variance +/(-)
Percentage of patients seen within two weeks of an urgent GP referral for suspected cancer	93%	92.51%	(0.49%)
Percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer is not initially suspected	93%	92.14%	(0.86%)
Percentage of patients receiving first definitive treatment within one month of a cancer diagnosis (measured from 'date of decision to treat')	96%	96.51%	0.51%
31-Day Standard for Subsequent Cancer Treatments-Surgery	94%	92.16%	(1.84%)
31-Day Standard for Subsequent Cancer Treatments-Anti Cancer Drug Regimens	98%	99.21%	1.21%
Percentage of patients receiving subsequent treatment for cancer within 31-days where that treatment is a Radiotherapy Treatment Course	94%	96.38%	2.38%
62 day wait - % treated in 62 days from GP referral	85%	79.22%	(5.78%)
62 day wait - % treated in 62 days from screening programme	90%	88.35%	(1.65%)
62 day wait - % treated in 62 days from consultant upgrade	90%	82.15%	(7.85%)

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.

During the period April 2018 to March 2019 three of the nine operational cancer standards were delivered for Somerset patients; the standards not met include the 2 week and 62 Day operational standards. The main factors influencing performance is an 18.8% increase in the

number of suspected cancer referrals which equates to 4,040 additional patients being referred for suspected cancer and an increase in the number of complex cases with patients often requiring multiple diagnostic tests prior to diagnosis and at times requiring treatment outside of Somerset. However, this increase in demand has led to the earlier detection of cancer; during 2018/19 there has been a 17.7% increase in the number of patients who have received a definitive cancer treatment following an urgent GP cancer referral (and equates to 346 patients). Both local Providers have 62 Day Cancer Improvement Plans in place in order to improve and sustain 62 day cancer performance.

4.28. Referral to Treatment Pathways

The performance scorecard in respect of elective access standards achieved for services delivered to Somerset patients, for the period 1 April 2018 to 31 March 2019 is set out below.

4.29. Somerset CCG Key Performance Scorecard (Somerset Relevant Population) between 1 April 2018 and 31 March 2019

Indicator		Standard	YTD 18/19	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%	84.41%	(7.59%)
	Average Median waiting time (2017-18)	7.2 Weeks	7.8	0.1 Weeks
	Number of Service User on incomplete RTT pathways (yet to start treatment) waiting in excess of 52 weeks	0	37	37
Reduce diagnostic waiting times	Percentage of Somerset Patients Waiting less than 6 weeks for a key diagnostic test or procedure	99%	86.13%	(12.87%)

4.30. Referral to Treatment – Standards

The NHS Constitution stipulates that 92% of patients referred for NHS consultant-led treatment should wait no longer than 18 weeks from referral to definitive treatment, unless clinically appropriate or at the patients discretion. Whilst Yeovil District Hospital NHS Foundation Trust recovered the national standard during 2017/18 performance has deteriorated to 91.1% in March 2019 and Taunton and Somerset NHS Foundation Trust has continued to not deliver the standard, falling behind their improvement trajectory from August 2018. The performance at both local Providers has declined since the summer as a consequence of the 18.8% increase in cancer demand which has led to the displacement of routine capacity. This has also led to an increase in the number of patients awaiting treatment whose wait exceeds 18 weeks as well as an increase in the number of patients at Taunton and Somerset NHS Foundation Trust whose wait exceeds 40 weeks.

In October 2018 a Long Waits Action Group was established with membership from Taunton and Somerset NHS Foundation Trust, Yeovil District Hospital NHS Foundation Trust and

Somerset CCG and this group has met weekly to track the delivery against the plan. However, the improvement ambition has not been met and as at March 2019 on a Somerset commissioned basis there were 37 patients waiting in excess of 52 weeks; 33 of these patients were awaiting treatment at Taunton and Somerset NHS Foundation Trust.

The CCG continue to monitor progress against improvement plans and is working with all Providers to develop plans to improve performance during 2019/20.

4.31. Diagnostic Waiting Times – Standards

The NHS Constitution standard for diagnostics is that 99% of patients should wait less than six weeks for a diagnostic test or procedure and on a cumulative basis during 2018/19, 86.1% of patient on the waiting list had been waiting six weeks or less. Performance deteriorated during the first 6 months of 2018/19 as a consequence of an increase in waiting time breaches at Taunton and Somerset NHS Foundation Trust. The Trust experienced a significant increase in the number of patients waiting in excess of 6 weeks for an MRI, Echocardiogram or Endoscopy resulting in deterioration of the waiting times standard. The Trust has ongoing capacity challenges within MRI, Echocardiography and Endoscopy (namely colonoscopy and gastroscopy) which are underpinned by an increase in demand (routine and cancer) further compounded by workforce constraints. The Trust has increased capacity during the latter 6 months of 2018/19 via insourcing securing additional mobile capacity and continues to strengthen the workforce, identify and secure additional capacity and implement internal efficiencies in order to improve performance. The Trust has developed a business case to further increase capacity during 2019/20 in order to recover the standard by March 2020.

4.32. Self-Certification by the Accountable Officer

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

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

Signed:

David Freeman
Accountable Officer
Somerset Clinical Commissioning Group

Date: 23 May 2019

ACCOUNTABILITY REPORT

David Freeman

Accountable Officer

23 May 2019

Corporate Governance Report

5. Members Report

The membership of Somerset CCG Governing Body and Leadership Team is set out in Table 1 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.

The key roles undertaken by the Governing Body Non-Executive leadership (as at 31 March 2019) are set out in the table below:

Name	Governing Body Appointment	Governing Body Lead Roles
Lou Evans	Lay Member Non-Executive Director (Governance and Audit)	Deputy Lay Chair Conflict of Interest Guardian Cyber Security Non Executive Lead Audit Committee Chair Remuneration Committee Chair
David Heath	Lay Member Non-Executive Director (Patient and Public Involvement)	Primary Care Commissioning Committee Chair Remuneration Committee Member Audit Committee Member Quality and Safety Committee Member
Vacant	Lay Member Non-Executive Director (Finance and Performance)	Finance and Performance Committee Member Remuneration Committee Member
Dr Basil Fozard	Secondary Care Specialist Doctor Non-Executive Director	Remuneration Committee Member Quality and Safety Committee Member
Dr Jayne Chidgey-Clark	Registered Nurse Non-Executive Director	Quality and Safety Committee Chair Workforce Non Executive Lead Remuneration Committee Member Audit Committee Member Staff Champion Freedom to Speak Up Guardian

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.

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

5.1. Statement of Disclosure to Auditors

Each individual who is a member of the CCG Members' Report, confirmed at the Governing Body of 23 May 2019, the following:

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

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

5.2. Modern Slavery Act

NHS Somerset CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending 31 March 2019 is published on our website at http://www.somersetccg.nhs.uk/about-us/how-we-do-things/safeguarding-children/modern-slavery/

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. When we hear the term modern slavery, most people think this only exists overseas, but the Home Office estimates there are 13,000 victims and survivors of modern slavery in the UK. Modern slavery victims are among the most vulnerable people in our society and can be hesitant to seek help due to fear of their traffickers. Although modern slavery is considered a 'hidden' crime, many victims can be working or otherwise visible in the community, in a range of places such as nail bars, food outlets, car washes, factories, and the fishing industry.

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

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

- by supporting survivors and vulnerable people through the specialist services that we commission, we can enable them to recover safely and develop resilient, independent lives
- by influencing the development of the NHS workforce through access to national training, advice and resources we can better identify and support actual and potential victims of slavery
- by raising awareness of modern slavery through the CCG website and the safeguarding newsletter, we can support NHS staff to recognise the signs of modern slavery and understand the role they have to play

Table 1: Breakdown of CCG Senior Leaders and their roles in the CCG governance structure as at 31 March 2019

Name	Title	Committee Membership (voting and non-voting membership)							
		Governing Body	Clinical Executive	Audit	Remuneration	Joint Committee (Primary Care)	Quality and Safety	Finance and Performance	Health and Well Being Board
CCG Executive Leadership									
David Freeman	Chief Officer	✓	✓				✓	✓	✓
Alison Henly	Chief Finance Officer and Director of Performance	✓	✓			✓	✓	✓	
Sandra Corry	Director of Quality and Safety	✓	✓			✓	✓	✓	
Maria Heard	Director of Strategic Clinical Services Transformation	✓	✓			✓			✓
Adrian Boyce	Interim Chief Operating Officer	✓	✓			✓	✓	✓	
GP Practice Clinical Leadership									
Dr Ed Ford	CCG Chairman and GP Locality Delegate, West Somerset	✓	✓					✓	✓
Dr Amelia Randle	GP Locality Delegate, West and Central Mendip		✓			✓			
Dr Steve Edgar/ Dr Ian Wyer	GP Locality Delegate, South Somerset (job share)		✓						
Dr Alex Murray	Governing Body Member and GP Locality Delegate, Bridgwater Bay	✓	✓						
Dr Helen Kingston	GP Locality Delegate, East Mendip		✓						
Vacancy	GP Locality Delegate, North Sedgemoor		✓						
Dr Kate Staveley	GP Locality Delegate, CLICK		✓			✓	✓		
Dr Will Chandler	GP Locality Delegate, Taunton Deane		✓						
Non-Executive Leadership									
Lou Evans	Vice Chair and Non-Executive	✓		✓	✓	✓		✓	

Name	Title	Committee Membership (voting and non-voting membership)							
		Governing Body	Clinical Executive	Audit	Remuneration	Joint Committee (Primary Care)	Quality and Safety	Finance and Performance	Health and Well Being Board
	Director (Lay Member - Governance and Audit)								
Vacancy	Non-Executive Director	✓		✓	✓	✓			
David Heath	Non-Executive Director (Lay Member - Patient and Public Involvement and Chair of the Joint Committee)	✓			✓	✓	✓		
Dr Basil Fozard	Non-Executive Director (Secondary Care Specialist Doctor)	✓			✓	✓	✓		
Dr Jayne Chidgey-Clark	Non-Executive Director (Registered Nurse)	✓		✓	✓	✓	✓		
Public Health Leadership									
Dr Trudi Grant	Director of Public Health, Somerset County Council	✓							✓

6. Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

- make judgements and estimates on a reasonable basis

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

- prepare the financial statements on a going concern basis

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.

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 Freeman
Accountable Officer
Somerset Clinical Commissioning Group

Date: 23 May 2019

7. Governance Statement

7.1. Introduction and Context

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

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

As at 1 April 2018, the CCG is subject to directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 as follows:

In July 2018 the CCG was given a performance rating by NHS England of 'Requires Improvement'. It was agreed nationally that all CCGs in the Special Measure regime that remained in the overall category of Requires Improvement would remain in Special Measures. Therefore, Somerset CCG continued in Special Measures for 2018/19. Key areas of failure for the CCG were:

- Although strong working relationships have been cultivated with partners across the STP, further improvements are required to establish a disciplined approach to financial recovery in order to develop a robust Financial Recovery Plan.
- Improvement is required for recovery and maintenance of key performance measures, including implementation of sustainable solutions to ensure standards are maintained.
- Issues with workforce recruitment and retention need to be addressed across all sectors.

7.2. Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

7.3. Governance arrangements and effectiveness

The main function of the Governing Body of the CCG 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.
Somerset CCG is a membership body comprising of 66 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 works with the CCG and a range of GP clinical leads are engaged to work on specific workstreams.

The CCG has established a properly constituted Governing Body with the appropriate clinical, managerial and lay member skill mix, including: GPs, a secondary care specialist doctor, a registered nurse, a Director of Public Health, three independent lay members, the Accountable Officer and Chief Finance Officer. Three Member Practice representatives will be appointed to Governing Body in May 2019. Details of the membership and the attendance of those members are set out in Annex 2 to the Governance Statement.

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 a Staff Survey, 360 degree stakeholder survey and developing actions to address issues for development.

The following committees have been established by the Governing Body:

a) Clinical Executive Committee (CEC)
b) Audit Committee
c) Remuneration Committee
d) Joint Committee (Primary Care)
e) Quality and Safety Committee
f) Finance and Performance Committee

The remit of each committee is as follows:

Committee	Key roles and responsibilities
Clinical Executive Committee	GP Clinical Lead: Dr Alex Murray Executive Lead: Nick Robinson/David Freeman Non-Executive Lead: n/a The Clinical Executive Committee is the primary executive decision making body of the CCG, authorised to make decisions within the powers delegated to it by the CCG Governing Body and is accountable to the CCG Governing Body. Its main functions are: • responsible for developing the CCG strategy, clinical and other policies, and operational plans for consideration and approval by the Governing Body • within the strategic and operational planning framework agreed by the Governing Body, the Clinical Executive Committee is the

	primary decision making body responsible for delivery of these plans. It is held to account for progress against these plans • to oversee and performance manage clinical commissioning teams and to receive updates on key areas of responsibility • to oversee and performance manage all operational, financial, clinical and risk management issues • to oversee and performance manage the quality of commissioned services, quality being defined as clinically effective, personal and safe care • to ensure that the patient's view has been effectively considered in commissioning decisions made by the group • to receive reports on statutory corporate responsibilities including Information Governance, Emergency Preparedness, Health and Safety and workforce and inform the Governing Body on recommendations or areas of concern
Audit Committee	GP Clinical Lead: Dr Geoff Sharp Executive Lead: Alison Henly Non-Executive Lead: Lou Evans 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
Remuneration Committee	Non-Executive Lead: Dr Jayne Chidgey-Clark [Executive and Clinical Leads only attend upon invitation] 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 Will Harris Executive Lead: Alison Henly Non-Executive Lead: David Heath The Joint Committee has delegated powers of responsibility from the Governing Body to commission primary medical services and has responsibility to: • jointly commission primary medical services for the population of Somerset • make primary care commissioning decisions; • oversee the development and implementation of the primary care strategy and workplan

	• oversee implementation of the CCG statutory duty to improve the quality of primary care
Finance and Performance Committee	GP Clinical Lead: Dr Ed Ford Executive Lead: Alison Henly Non-Executive Lead: Vacancy The purpose of this Committee is to provide assurance to the Clinical Commissioning Group Governing Body on the Clinical Commissioning Group's finance and performance. The Committee will look at the overall Somerset system position in terms of finance and performance. As an assurance Committee of the Governing Body, it will hold to account the CCG Executive team for delivery of the financial and performance plan, and recommend further areas for turnaround and performance improvement. This will be done through: • reviewing the financial and service performance of the Clinical Commissioning Group against statutory financial targets, financial control targets and the annual commissioning plan • reviewing the Clinical Commissioning Group's financial, performance and improving value schemes (QIPP) agenda and provide assurance to the Board in the delivery against annual plans • reviewing performance improvement plans, identifying areas for further improvement or commissioner actions and monitors trajectories towards improvement • monitoring the overall process of financial planning across the system and reviewing through the 5 year financial plan • where finance and performance issues are raised then these will be highlighted to the Clinical Executive Committee, A&E Delivery Board and Elective Care Delivery Board to agree actions and mitigations (via the Clinical Commissioning Group's Chief Officer) to rectify the issue • ensure that the Committee agenda and papers take into account the risks on the Board Assurance Framework (BAF) and risk registers. The Committee will wish to be assured that matters of risk are being effectively managed.
Patient Safety and Quality Assurance Committee	GP Clinical Lead: Dr Kate Staveley Executive Lead: Sandra Corry Non-Executive Lead: Dr Jayne Chidgey-Clark The purpose of the Committee is to: • promote a culture within Somerset Clinical Commissioning Group that focuses on Patient Safety and Quality Improvement • provide assurance on all NHS Provider services governance arrangements and patient safety performance, through receiving exception reports on quality and safety issues, patient experience and safeguarding concerns and alerts for health services. The Committee will report areas of concerns and

	quality improvement to the Somerset Clinical Commissioning Group Governing Body • monitor serious incidents, incidents and action plans linked to key areas of responsibility where Somerset Clinical Commissioning Group: ➢ are Lead Commissioners ➢ have statutory responsibility ➢ or where responsibility falls directly to Somerset Clinical Commissioning Group for improving the quality of services • to ensure that key themes and lessons learned from serious incidents, safeguarding, domestic homicide reviews and significant event audits are identified and shared across all NHS providers for continuous quality improvement of service provision and to prevent re-occurrence • to monitor mortality data and review findings, including Learning Disability Mortality Reviews (LeDeR) and the implementation of improvement actions • monitor progress in promoting harm free care across all NHS providers to include a focus on organisational actions to reduce pressure ulcer incidence, falls, health care acquired infection and medication incidents • receive assurance from the Clinical Executive Committee that service strategy and redesign have prioritised quality and safety alongside service delivery efficiency • review service and pathway redesign proposals and make recommendations about patient safety concerns and outcome of quality impact assessments to the Clinical Executive Committee • receive focussed subject matter reports from the Clinical Executive Committee as required, with evidence that quality and patient safety issues and safeguarding alerts in respect of health services are fully considered, risks identified and reduced or mitigated • have oversight of the CCGs providers integrated quality dashboard and request attendance of providers, as required • provide a forum for representatives from the CCG's directorates to work collaboratively with members of the Committee to provide assurance around patient safety/quality improvement aspects of the Health and Care Strategy • receive reports on the CCGs duty to promote quality improvement in primary care. Assurance for quality and safety in primary care is currently discharged through the Joint Committee for Primary Care • receive reports on patient experience of NHS services from patient surveys, real time feedback, Friends and Family test and complaints and PALS enquiries and Health Watch to identify lessons learned and inform commissioning • ensure engagement with GP Localities and practices, and establish feedback mechanisms so that lessons learnt from complaints and incidents are shared in order to improve and inform services • to receive reports on the quality and safety of services jointly commissioned with Somerset County Council

The CCG's performance of effectiveness and capability is subject to continuous assessment including regular checkpoint assessments with NHS England. The CCG has participated in the NHS England CCG 360 degree Stakeholder Survey and will use this feedback to inform its development plans. The results from the 360 stakeholder survey for 2018/19 indicate a number of areas that require improvement, including:

- how the CCG commissions/decommissions services
- delivering value for money
- reducing health inequalities

The results of the survey require more detailed analysis and the results will be reported through to the Governing Body.

During 2018/19, the CCG has been implementing the findings of the independent capacity and capability review held in 2017/18 and has also been participating in a newly framed special measures regime which has prompted the new Commissioning Capability Programme led by NHS England. There has also been a considerable programme of work to address the issues identified by the survey, review and other feedback.

The CCG is progressing plans to meet the requirements of Community and Patient Involvement Indicator which forms part of the IAF framework:

- the CCG constitution, revised February 2019 now states explicitly how it involves the public in governance how it is assured in relation to public involvement. Webpages actively promote involvement and participation. There are 3 Lay Members on the Governing Body, and a Patient Participation Group representative observer
- the current public engagement strategy is being revised and will make clear how involvement duties will be met. Commissioning plans are updated and priorities are explicit in explaining how public engagement influences planning, documents available. Engagement is underway to involve patients/public in writing the new strategy. A new Communications and Engagement structure has now been agreed and a new senior Head of Communications and Engagement appointed (set to take up post April 2019)
- Healthwatch and the Patient Participation Group Chairs network are invited to comment on the work of the CCG over the past year and their comments/feedback will be included in the publication of the annual report
- there are many positive engagement activities being undertaken at SCCG. We have identified opportunities to improve this ensuring a wider reach and involvement. Further improvements are also being introduced in how these are captured and/or co-ordinated. Improvements are planned to promote and publicise active engagement. Webpages are re-designed to inform patients and the public about how they can contribute or become involved in commissioning. Further work required to ensure a wider involvement of seldom heard and BME
- actions are being developed to further embed patient and public participation as part of the CCG's revamp of the commissioning cycle. There is some good practice (mental health, childrens (parent-carers) and across a range of long term conditions projects. The Operational Plan sets out a detailed plan for

embedding involvement best practice Training planned for the Governing Body, programme leads across the CCG to ensure statutory duties are understood, embraced and implemented

- quarterly patient engagement reports capture feedback from engagement activities, from Lay Users and partnership work with organisations such as Healthwatch. Fit for my Future 'You said, we listened' describes how we engaged and made changes based on what people told us. The revised strategy will build on this model
- governance processes and reporting have improved to raise the profile/importance of engagement and involvement. The CCG is strengthening mechanisms to document engagement evidence how user voices inform decision making and provide assurance to governing body
- the CCG has supported participation activity with local communities and engaged with groups who experience difficulties accessing health services. Participation/engagement with groups ensuring people with protected characteristics are involved is in place. Further work is required for proactive engagement to ensure needs of BME and seldom heard communities are met
- auditing and monitoring of equalities participation in CCG activities/commissioning needs to be undertaken to document and evidence compliance and best practice
- training is planned to support governing body, managers and staff in effectively and confidently engaging patients and the public in commissioning. Improved governance, training and support for lay users is planned and Easy Read training for key staff
- contract monitoring with providers sets out schedule requirements for public involvement. These are monitored through quality meetings but need to be strengthened with robust monitoring tools, audits and evidence templates

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

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

In terms of improving Stakeholder relationships:

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

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.

7.4. UK Corporate Governance Code

The CCG are not required to comply with the UK Code of Corporate Governance. However, the CCG have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG. For the financial year ended 31 March 2019, 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.

7.5. Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the Clinical Commissioning Group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Risk Management Arrangements and Effectiveness

7.6. The Clinical Commissioning Group Risk Management Framework

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

The Somerset CCG Risk Management Strategy and Policy sets out the leadership and arrangements for risks management across the CCG. This policy supports the adoption of an open culture where individuals are encouraged to report adverse incidents and near misses, to ensure the CCG can use learning to continuously improve health services and the way in which these are commissioned to meet the needs of the population.

The CCG implemented new governance arrangements as a result of reviews carried out during 2017/18. This review incorporated changes to the CCG's committees and their delegated functions. A new committee structure began to be embedded during 2018/19 and each committee has a clear responsibility in relation to assurance and risk.

During the year there has been a substantial change in the manner in which the CCG operates its business planning and governance as part of the Somerset

System Transformation Plan (STP). This has necessarily impacted on governance arrangements, assurance flows and the organisational structure within the CCG.

During the year foundation work has been conducted to review and revise the CCG's Governing Body Assurance Framework to focus upon the CCG's priorities in relation to:

- System and CCG Turnaround
- Health and Care Services Review (Fit for My Future)
- Business as Usual

A revised Assurance Framework has been agreed by the Governing Body, but has not yet been populated with assurance flow information to reflect the changed arrangements. This work will carry forward into 2019/20 as the new STP system has begun to mature with new system wide assurances flowing from STP work programmes which be incorporated into the revised framework. This will provide a foundation for the development of a Somerset health and care system wide approach to governance and risk management which incorporates:

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

- alignment to the achievement of the NHSE Improvement and Assessment Framework (IAF)

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

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

7.7. Capacity to Handle Risk

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

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

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.

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

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.

7.8. Risk Appetite

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.

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

Risks in this category shall have individual action plans for risk treatment. Risks are proactively managed and reported on at intervals defined in the action plan, but as a minimum requirement quarterly to the Clinical Executive Committee and to the Somerset CCG Governing Body. Between quarterly reviews, all new risks entering onto the risk register are reported to the Clinical Executive Committee and the Governing Body on a monthly basis by exception.

7.9. Risk Assessment

The CCG maintains its risk registers in an electronic computer database system. Directorate risk registers are populated and updated on an ongoing basis. Quarterly extraction and review of corporate risks (those scoring 12 and above) are summarised to describe the risk in a manner which is accessible to the public and includes an appropriate action plan for further mitigation in accordance with SMART action plan principles.

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

- Ambulance service response times
- Adult and children's mental health services
- the CCG's financial budget overspends due to under delivery of the Quality, Innovation, Productivity and Prevention (QIPP) savings targets, overspends against activity related contracts and national increases in drug tariffs
- Cyber-security
- access to services waiting times, including waits in A&E and from referral to treatment
- the quality and safety of some services identified through CCG quality monitoring systems and / or through CQC regulatory inspections. In 2017/18 this was a particular concern for the 111 and Out of Hours GP Primary care service provided by Vocare in Somerset
- future sustainability of services at Weston Area Health NHS Trust
- workforce sustainability
- the delivery of the STP Health and Care Services Review 'Fit for My Future'

- managing the potential risks relating to a no deal EU Exit

7.10. Other sources of assurance

Internal Control Framework

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

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

All reports presented to the Governing Body include identified risks. All strategic documents are reviewed by the Clinical Executive Committee and clinical risks to delivery considered. The effectiveness of the Committee Structure is continually reviewed internally via the Governing Body review programme and against best practice where available. During 2018/19 the CCG committee structure was revised following the conclusion of an internal governance review.

During 2018/19, the CCG Governing Body commenced a Health and Care Strategy review as part of the STP development. The CCG Governing Body reviews the organisational compliance and delivery of the strategic objectives against the Assurance Framework and Corporate Risk register on a quarterly basis.

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 2018/19.

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

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

The revised statutory guidance on managing conflicts of interest for CCGs (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

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.

Overall, the report raised 15 recommendations relating to the CCG's management of conflicts of interests, including ten medium level and five low level recommendation. The review found that there is room for improving the CCG's controls for the management of conflicts of interest but with no significant areas of concern, and there were not any major instances of non-compliance with the current controls, leading to a final assessment of moderate assurance over the control design, and moderate assurance over the control effectiveness. Each of the recommendations will be implemented in 2019. The results of the audit are outlined in more detail later in the Governance Statement.

7.11. Data Security

Following legislative changes in May 2018 and the introduction of the General Data Protection Regulation and UK Data Protection Act 2018, any information breaches are assessed and where appropriate, reported through the Data Security and Protection (DSP) Toolkit, as set out in the NHS Digital guidance document – 'Guide to the Notification of Data Security and Protection Incidents'. The Security of Network and Information Systems (NIS) Directive also requires reporting of relevant incidents to the Department of Health and Social Care. As there is no link between the DSP toolkit and the Strategic Executive Information System (STEIS), DSP Toolkit reportable incidents also need to be reported on STEIS. Somerset CCG had no incidents which met the DSP Toolkit reporting threshold during 2018/19.

Data Quality

The CCG has continued to develop data quality in conjunction with the CSU during the 2018/19 financial year.

Information Governance

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

All organisations that have access to NHS patient information are required to provide assurances that they are practising good information governance and use the DSP Toolkit to evidence this through publication of annual assessments. The DSP Toolkit is part of a framework for assuring that organisations are implementing the ten

National Data Guardian data security standards as well as their statutory obligations on data protection and data security. The annual assessment and submission process provides assurance to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

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

Over 95% of all staff had completed their information governance training by 31 March 2019.

Somerset CCG has submitted a Data Security and Protection (DSP) Toolkit for 2018/19 with a rating designation of 'exceeds expectations'. As the DSP Toolkit is a new assessment and has substantially changed in structure from the old Information Governance Toolkit, it is not possible to provide a direct comparison of progress from previous years. In 2017/18, Somerset CCG published an IG Toolkit assessment at Level 2, with a score of 79%.

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

Business Critical Models

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

Third party assurances

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 payroll services.

7.12. Review of economy, efficiency and effectiveness of the use of resources

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 judgements. The Committee reviews the system of governance, risk management and internal control, across the whole of the organisation's activities.

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

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.

As well as overseeing the anti-fraud, bribery and corruption arrangements in place within its providers, the CCG also needs to ensure its own counter fraud measures remain robust. Somerset CCG has well established counter fraud arrangements in order to help the organisation achieve the standards set out by the NHS Counter Fraud Authority. The CCG engages an Accredited Counter Fraud Specialist to implement an ongoing programme of anti-fraud, bribery and corruption work across the whole organisation. During 2018/19 work has involved the delivery of an annual work plan which follows the NHS Counter Fraud Authority strategy to ensure the organisation's resources are protected from fraud, bribery and corruption, as well as addressing all four key areas of the national counter fraud strategy, namely strategic governance, inform and involve prevent and deter and hold to account.

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

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 deterrent effect on other employees and prevents other incidents of fraud.

In 2018/19 the CCGs LCFS delivered a training session to new CCG staff to increase awareness of fraud across the organisation, and the CCG also shared LCFS briefings with all staff through its 60 seconds bulletin, which covers key areas of learning from within the sector.

The CCG continues to set a challenging QIPP programme, which sees projected QIPP savings of around £28m being delivered in 2018/19. These QIPP schemes are monitored to ensure key risks and issues are identified and decisions taken by 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 and monitoring are in place to ensure no double counting across organisations.

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

To support this, the CCG has set up a Finance and Performance Committee, chaired by the Chair of the Audit Committee of the CCG, which is looking at the financial position and QIPP opportunities across the range of services commissioned. This

group meets monthly to review the position and has an active work programme which is actioned through the CCGs Leadership Team.

As part of the developing and continued working towards a single system of finance, activity and workforce, the individual operational plans of the Somerset Health Partners have been worked up, cross checked and triangulated as one through established joint working and strengthened governance as a collective partnership including the County Council. This is part of the system's ongoing open book approach to managing itself, through planning and delivery. The Somerset approach to managing the system as a single health and care system, supported by a long term strategy is being developed, with the more immediate development of a financial recovery plan, to ensure alignment and delivery of the aims for the system as a whole. This forward strategy will build on and refresh the already STP approved estates programme, capital plans, and digital plans. The recovery plan will focus on managing demand and reducing cost across the system. This will include a focus on clinical variation (using Rightcare, Getting It Right First Time, Model Hospital, Reference Costs and more benchmarks), is looking at elective and non-elective pathways, medication, continuing health care, and optimisation in both the short term and longer term through changes to the models of care. We are also planning a system-wide approach to the efficient and cost effective use of bed capacity across all STP Partners.

7.13. The Better Care Fund

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 2018/19 through a signed agreement under Section 75 of the National Health Service Act 2006. Somerset County Council received additional funding in 2018/19 through the improved Better Care Fund (iBCF), which has been pooled as part of the Section 75 agreement. The iBCF funding can be spent on three purposes:

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

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.

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.

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

- plans are jointly agreed
- NHS contribution to adult social care is maintained in line with inflation

- agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
- managing Transfers of Care (a new condition to ensure people's care transfers smoothly between services and settings)

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

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

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

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

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

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

monitoring of expenditure was completed through the Joint Commissioning Board finance Sub Group

- preparing and submitting reports to the Health and Wellbeing Board as required by it which shall include the submission of copies of the Quarterly and Annual reports to the Joint Commissioning Board

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

7.14. Control Issues

In January 2019, a month 9 Governance Statement Report was submitted to NHS England. This return highlighted a number of areas of control where significant performance issues have been experienced during 2018/19. These areas, along with the mitigating actions, are shown in the table below.

Control Issue	Mitigating Actions in Place
Quality and Performance – Accident and Emergency Performance Referral to Treatment Performance 52 Week Wait Performance Mental Health and Dementia Performance	The CCG has controls in place for managing Provider performance, including monthly Access and Performance Group Meetings (APG) with Taunton and Somerset NHS Foundation Trust. This meeting includes representation from both NHS England and NHS Improvement. A monthly Sustainability and Transformation Programme (STP) performance meeting is held, with attendance from all System Partners, where performance is reviewed in detail and remedial actions recommended and agreed. To support this meeting a detailed data-pack is shared which clearly identifies any areas of under-performance or emerging issues for discussion; this is reviewed in conjunction with the Single Version of the Truth Activity and Performance Tool which provides a view of elective and urgent care activity and performance at a more granular level (with drill through functionality). Recovery focus has been specifically focused on 52-week waiters and cancer performance, where recovery trajectory actions and trajectories have been agreed with weekly operational calls to focus on delivery and any mitigations needed across the providers. The Clinical Commissioning Group has improvement plans in place with progress monitored through the APG or monthly contract meetings with discussions also taking place at the STP, Professional Executive Group (PEG) or Delivery / Programme Boards as appropriate. Improvement plans in place include the following: • 62 day Cancer - T&S & YDH • Diagnostics - T&S & YDH • NHS 111 and Out of Hours – Vocare The Recovery Action Plans remain under continual review with progress monitored; the CCG is in attendance at a number of internal Trust meetings and where there is any divergence from plans immediate actions are put in place to address this shortfall or new actions are agreed to address any emerging issues. The Clinical Commissioning Group continues to work with the system to implement schemes for demand management, which

	include Emergency Demand Mitigation Schemes (stranded patients, rapid response, single point of access, 7 day working, care homes and home first) and review of other referral demand (urgent and elective care) using external benchmarking such as Rightcare as well as internal data to identify areas of unwarranted variation with improvement schemes agreed via the Delivery Boards as required. The CCG also identified an issue in respect of the Out Of Hours (OOH) and 111 service, which was contributing to the increase in A&E activity and emergency admissions. Immediate discussions commenced with the service provider, which concluded that the provider did not have sufficient workforce to provide the contractual level of performance and following contractual negotiations notice was given and short term measures put in place, including changing OOH provider on a mutually agreed basis and support arrangements put in place around the 111 service. The Clinical Commissioning Group has strengthened the monitoring and oversight of the national Clinical Commissioning Group assurance framework (CCG Improvement and Assessment Framework) introducing monthly oversight wherever possible and with many of these objectives incorporated into the new Integrated Quality and Performance Report (and Governing Body Exception Report) that have both been developed during 2018/19.
Quality and Performance – Ambulance Services	South Western Ambulance Services NHS Foundation Trust (SWASFT) has been experiencing some challenges in the delivery of Ambulance Response Programme (ARP) standards. As a consequence there has been a system wide response that aims to support SWASFT achieve these targets where possible. The primary focus has been to reduce the call stack volumes. The SWASFT call stack is defined as the total number of active calls at a given time that do not have a double crewed ambulance or rapid response vehicle available to attend. In order to mitigate this the following trust wide actions are being taken: • A SWASFT Commissioner Joint Plan that aims to support SWASFT across the following areas: o NHS 111 services o High Intensity Users o Healthcare Professional Calls o Falls o Mental Health o Frailty o Handover Delays o Alternative Pathways • There is also a SWASFT business case that aims to: o Increase the numbers of employed staff o Realign the rotas to maximise existing staff o Purchase additional ambulances

7.15. Counter Fraud Arrangements

The 2018/19 Annual Counter Fraud Work Plan was developed to support the CCG in implementing appropriate measures to counter fraud, bribery and corruption. Having appropriate measures in place helps to protect NHS resources against fraud and ensures they are used for their intended purpose, the delivery of patient care.

The Counter Fraud work plan for 2018/19 was risk-based and has been aligned to the Standards issued by the NHS Counter Fraud Authority in February 2018. The work plan was produced taking into account:

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

The Counter Fraud service is provided by BDO LLP, 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.

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

7.16. Head of Internal Audit Opinion

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

The role of internal audit is to provide an opinion to the Governing Body, through the Audit Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed. The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- *An assessment of the design and operation of the underpinning Governing Body and 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 is forecast to deliver its planned in year deficit of £9m which will result in £9m anticipated Commissioner Sustainability Funding, so it will record a breakeven position. As a result, the cumulative deficit that it has built up will total £3.6m.*
- *The CCG has displayed strong controls in relation the key financial system processes. Progress has been made during the year with the implementation of the actions arising from the audit work.*

During the year, Internal Audit carried out its planned audit programme and the table below sets out a summary of the audit reports and the level of assurance provided:

Area of Audit: Key Financial Controls; **Director:** Alison Henly, Director of Finance, Performance and Contracting		
Design: substantial	**Effectiveness**: substantial	**Recommendations**: none

Summary of report:
The purpose of the audit was to provide assurance over financial controls, general ledger access controls, control account reconciliations and journal preparation and entry. In addition, assurance over the accuracy of the financial reports was provided.

Overall, no key findings were identified, processes around the general ledger were adequately controlled.

A number of areas of good practice were identified:

- a Finance report is presented to the Governing Body and testing highlighted that financial information included can be accurately traced back to supporting documentation
- for journal entries tested, they were supported with valid evidence and approved appropriately. At the time of the audit, no journals had been self-authorised
- the Financial Control and Governance Assessment has been completed quarterly with explanations and action plans in place to address any areas of non-compliance
- sample testing on user access to Oracle (existing staff and recent leavers) did not identify any exceptions

No recommendations were raised

Area of Audit: Conflicts of Interest; **Director:** Adrian Boyce, Interim Chief Operating Officer

Design: moderate **Effectiveness**: moderate **Recommendations**: 10 medium significance, 5 low significance

Summary of report:

The audit was undertaken to provide assurance that the CCG is complying with the Revised statutory guidance on managing conflicts of interest for CCGs (June 2017).

The revised statutory guidance on managing conflicts of interest requires CCGs to undertake an annual internal audit of conflicts of interest management.

The following aspects of the CCG's management of conflicts of interest were considered to be good practice:

- the CCG has a clearly documented and well detailed policy to provide staff with guidance on how to manage conflicts of interest and gifts and hospitality
- there are simple and user friendly mechanisms in place to enable staff to make declarations of interest and gifts and hospitality
- conflicts/declarations of interest are covered as standing agenda items at meetings of the Governing Body and sub-committees of the Governing Body
- there are robust procedures to ensure that conflicts of interest are considered and managed during the contract bidding process
- guidance for staff on how to manage breaches in policy relating to conflicts of interest is clearly documented and available within the CCG policies

Opportunities for enhancement

Recommendations have been raised against each of the areas of the assessment and summarised below:

Governance Arrangements

- Although compliant at the time of the audit, it was recommend that a further lay member is recruited, given the finance and primary care roles going forward.
- Prior to staff starting in their role after the recruitment process, the CCG should complete a checklist process to confirm all recruitment processes have been appropriately followed. Where this highlights that the declarations of interest documentation has not been completed. This should be followed up prior to the individual's start date with the CCG.
- The CCG should ensure that all staff involved in procurement projects have completed on-line conflicts of interest training.

Registers of interest, gifts and hospitality and procurement decisions

- In addition to sending reminders about declarations the CCG should carry out spot checks on a regular basis, selecting a sample of staff to confirm they have made and/or updated their declaration, including nil returns, in the past 6 months as per requirements.
- To undertake a comparison of the staff listed to complete their on-line training to the staff who have entered their interests on the on-line system to identify if there are any further staff missing from the register.
- To consider conflicts of interest training to the Governing Body, committee members and senior members of staff, with the introduction of the new Governance Handbook.
- To discuss with the CSU developers of the on-line system whether improvements could be made so that user errors are minimised, for example, changes are only saved if the user presses 'submit'.
- All CHC Funding Appeals Panel members should complete their declaration of interests using the electronic system.
- Actions to mitigate the risk of conflicts record on the register of interests should be more detailed to indicate how the actual risk of the interest will be managed as opposed to the

generic statement currently used.

- Details recorded on the online register of gifts and hospitality should be updated to include fields for the officer reviewing or approving the declaration, any previous gifts offered or accepted by this offer or/supplier and the reasons for accepting or declining the gift.
- Details within the procurement register should be updated to include a separate field for how any declared interests will be managed.
- CCG policy on the publication of registers should be updated to include the requirement for updating the register at defined regular intervals (ie. monthly). Additionally any registers specific to individual committees that are published online should be kept up to date to ensure details are current.
- Consideration to be given to ascertaining whether the on-line register system could be linked to the internet page, so that real-time information is provided.

Decision making processes and contract monitoring

- Ensure that when discussing and recording declarations of interest during committee meetings that there is also consistent discussion and recording of the actions that will be taken to mitigate any risks arising from the declared interests, specifically noting how the declaration will be managed during the discussions to be carried out during the meeting.

Area of Audit: Continuing Healthcare; **Director:** Sandra Corry, Director of Quality and Patient Safety

Design: moderate **Effectiveness**: moderate **Recommendations**: 4 medium significance, 1 low significance

Summary of report:

The purpose of this review was to consider the CCGs arrangements for managing the risks associated with Continuing Healthcare.

The following areas of good practice were identified:

- There is an operational policy in place describing the way in which the CCG will implement the NHS Framework for Continuing Healthcare 2012. It was discussed that this policy would be updated in light of the new framework launched in October 2018, however it should be noted that at the point of audit, the new framework could not be referenced. It is understood the new policy content will also reflect the agreed partnership working with the Somerset Local Authority.
- Contract reviews with CHC providers are undertaken with a clinician in order to review the quality and safety of the provision clinically as well as general compliance with the contracts.
- The Personal Health Budget (PHB) process has been reviewed by the CCG; new documentation has been drafted and it is being trialled with three PHB recipients.
- The team is currently going through a time of transformation in order to ensure continuing service improvement;
- The appeals process is documented, appeal panels minuted in line with NHS England agenda and Caretrack is updated with the progress of the appeal.
- QIPP delivery is monitored and presented quarterly to the CHC Strategic Group meeting. A review of care needs on PHBs, high cost cases and learning disability cases has delivered a saving of £753k in the first four months of 2018/19. Total QIPP delivery is £2m by the end of month 4.
- Benchmarking CHC against other CCGs within the South West is completed and reported to the CHC Strategic Group meeting.
- Care provider contracts include the standard NHS Terms of Contract.
- Quarterly information split by month is provided on the CHC performance dashboard detailing information such as: the number of CHC checklists received, number of fast track applications received, CHC spend, reviews overdue, completed and heard at panel and number of appeal,

enquiries and complaints.
- A two day workshop has been undertaken with Somerset County Council to ensure all processes between the CCG and LA are agreed in order move forward with CHC cases in the most efficient and effective way.

Opportunities for enhancement
Recommendations have been raised against each of the areas of the assessment and summarised below:

Contracts and Contract Monitoring of Care Providers
- All providers that have not received a contract review meeting in the last 12 months should be scheduled. Any services commissioned by the CCG should, as a minimum, have an annual contract review. Consideration should be given to reviewing the level of contract monitoring required so that it is proportionate to the level of risk associated with the care provider. The risk assessment criteria could review the annual spend with the provider, evidence from routine monitoring, CQC reports, market risk, complexity and volume of service users. This would help ensure that all providers are reviewed at a frequency that has been appropriately considered by the CCG.
- Contracts and/or NVA agreements should be signed. The CCG should consider whether it could delay payments to providers where contracts have not been signed.

Level of inappropriate positive checklists
- Consideration should be given to discussing with other South West CCGs their approaches to establish whether there are processes or training that could be shared and implemented.

Lack of financial checks to confirm that PHB funds are used to provide the care specified
- Consideration should be given to documenting the role of Finance and the role of the PHB Assessor in reviewing the way in which the PHB is spent. Contract review meetings should be scheduled with Compass annually, to bring the review process in line with Enham and to ensure they are complying and performing within the terms of the contract. Where there is no response from the PHB recipient regarding their statements within 4 weeks of the request date, consideration should be given to discussing with the patient about suspending their payment until this is received. In light of the changes the new framework will introduce from April 2019, it is likely that PHBs will increase. It is recommended that a PHB audit is undertaken in 2020/21 to review the process in more detail.

Resource pressures
- To continue with monitoring and reporting to the CHC Senior Managers and senior staff at each of the four localities the status of the completion of reviews with the existing staff resource and the timeframes for estimated completion date.

Area of Audit: STP Governance and Support; **Director:** Ian Triplow, STP Director for System Development

Design: moderate **Effectiveness**: N/A **Recommendations**: 2 medium significance

Summary of report:
This audit was undertaken to review the governance and support arrangements for the Somerset Sustainability and Transformation Partnership (STP).

The following areas of good practice were identified:
- The STP and CCG system governance structures have been established and mapped to give clear reporting and decision making routes on both system and CCG internal matters in relation to the STP delivery.
- The CCG's Governing Body Assurance Framework (GBAF) has been revised to link to the Somerset health and care system strategic priorities. The Governing Body has framed the strategic risks/priorities to align to the system vision.

- The Vision for the Somerset health and care system has been established and communicated to the Governing Body / Boards of the individual STP organisations. In addition to the one page vision statement, a five page narrative document, setting out the ambition, changes required, the five priority areas of focus for health and care and the Somerset health community's commitment to change, has been developed.
- A Somerset STP Memorandum of Understanding 2018-21 (MOU) has been agreed by all stakeholders. The Somerset System Leadership Board (SSLB) which is the ultimate decision making group for STP delivery and monitoring, has been set up and described in the MOU. A Somerset system control total has been agreed with Regulators. However, at the time of signing the MoU there was an unidentified gap to this. All partners within the system have committed to identifying mitigations to close this gap during 2018/19 as part of the quarterly review process, alongside reviewing organisation delivery against savings programmes.
- A system PMO function has been set up and a 'mobilisation pack' developed which documents the main contacts of the STP, information flow pathways, business case approval process and projects delivery gateways and standard report templates. This PMO function has been liaising with the Somerset System's Trusts in ensuring each Delivery Board (DB) can be set up in a consistent manner and that there is a process for projects to be approved/monitored in a timely manner.
- At the time of the audit, some of the programme /delivery boards had been set up with the key clinical/operational personnel defined. We reviewed the terms of reference for four programme / delivery boards (Elective Care Board, A&E Care Board, Alliance Development Committee and the Local Workforce Action Group) and the October to December 2018 meeting minutes. We can confirm that other partners; for example GPs and Ambulance Services are involved in the relevant Delivery Boards (A&E and Elective Care), and a reporting route has been set up.
- Monthly highlight reports are being sent from each Delivery Board to Programme Executive Group (PEG) and SSLB. We reviewed the November highlight report. It is in a standardised format and highlights the key actions from the previous month, the priorities for the following month and any decisions or requirements needed from PEG and/or SSLB. The aim is to have consistent system wide reporting. Workbooks are completed manually each month and highlight reports will automatically be generated within the workbook. A risk and issue log is also included in the report.
- NHS England & NHS Improvement conduct stock takes on a quarterly basis to monitor STP progress status. Actions are initiated to address issues identified from the stock takes. From a review of the draft minutes from the November stock take it was apparent that recent developments in clinical engagement were acknowledged and the challenge for the system will be how the plans are delivered both financially and operationally. It is understood that the stocktakes are discussed through the PEG and SSLB and the actions will be presented in the ICS development action plan which is in draft at present.
- A Fit for My Future (FFMF) Strategy has been produced, which proposed a number of priorities for change in Somerset. The FFMF has been approved by the Governing Body in November 2018, confirming that the Group B proposals should be taken forward for implementation through the STP Delivery Boards and the Group A proposals needing formal public consultation. This will ensure that there is engagement with patients, carers, the public and their representatives.

Opportunities for enhancement

Recommendations have been raised against each of the areas of the assessment and summarised below:

STP support structure

- Once a Delivery Board is fully set up with all projects identified for Somerset STP, a governance structure by work-stream should be defined to show clear routes of decision-

making and accountability for each project. Members of the groups should confirm that they have been given delegated powers from their organisations to make decisions (a limit or range may need to be specified);
Management of conflicts of interest processes to be documented in the MoU and Terms of Reference for the Delivery Boards;
Consideration for further development of the STP structure to ensure that there is a forum for discussing programme inter-dependencies, operational, performance and financial issues.

Governance structure

- A STP risk register should be set up and monitored at the PEG and SSLB on a monthly basis and provided to the partner organisations. Progress on actions taken to address the risks to be included in the reports with named individuals assigned.
  Risk Management processes to be documented and agreed with input from Risk Managers from partner organisations.
  The CCG to discuss the System Risk Register alongside its Governance Body Assurance Framework and Corporate Risk Register. A report route back to the PMO with observations / challenge on progress to be determined.

Area of Audit: Cyber Security; **Director:** Adrian Boyce, Interim Chief Operating Officer

Design: moderate **Effectiveness**: moderate **Recommendations**: 2 medium significance

Summary of report:

This audit appraised the design and effectiveness of the CCG's procedures for identifying and protecting its information assets and managing its cyber security risks on an ongoing basis. The work was designed to provide an assessment of the information and cyber security arrangements that are in place but cannot provide absolute assurance that the CCG would withstand an attack of its systems.

The following areas of good practice were identified:

- Cyber Security Risks have been identified and included in the corporate risk register.
- The Information Governance, Records Management and Caldicott Committee, meets on a quarterly basis and reviews cyber security matters, and also receives quarterly cyber security reports which are discussed.
- Cyber Security awareness training was provided to the CCG's Governing Body in June 2018 followed by Audit Committee training and staff are made aware of potential cyber threats through regular awareness communications.
- Routine network monitoring is in place for potential cyber threats, intrusion detection and targeted phishing attacks.
- Roles and responsibilities for cyber security have been established, with the responsibility of the CCG Governing Body, with executive and operational delivery within CCG and, where relevant, delegated to the IT Delivery Partner. Information Governance Lead (CCG Data Protection Officer) being responsible for cyber risks at the CCG.
- All internal network traffic is continuously monitored for unusual/suspicious activity.
- All network ports are restricted and only approved devices can attach to the CCGs networks.
- There are appropriate anti-malware controls in place which are updated every 30 days or sooner if a potential cyber threat is identified.
- The CCG utilises full disk encryption of hardware devices to encrypt hardware operating systems and files – this is key for hardware such as laptops where there is a risk of loss or theft of a device resulting in data compromise.
- Sufficient access controls exist for all users including those with privileged access rights whose activity is logged and reviewed for appropriateness.
- A sufficient password policy is in operation and default application passwords are changed.

Opportunities for enhancement
Recommendations have been raised against each of the areas of the assessment and summarised below:

Identification and prevention of cyber threats
- The CCG's cyber-security action plan should be reviewed and presented to the Information Governance, Records Management and Caldicott Committee for progress updates to be made. There should then be a formal monitor and review process implemented.
  All progress reports should be presented to the Governing Body to provide full transparency of cyber-security governance and awareness. Linkages should be made to the quarterly operational cyber-security reports provided by the CSU.

Procedures for responding to a cyber security incident
- The CCG should update its Incident Reporting Policy to encompass cyber-security incidents, and ensure that the identified roles and responsibilities are noted, together with the approved response to cyber incidents.
- This should be formalised and approved by the Governing Body and made available to all staff. The policy should be subject to routine review in accordance with the agreed cycle.

An additional audit concerning Primary Care Commissioning has also been commissioned but the report is currently pending.

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

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

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

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

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

7.18 Conclusion

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

Signed

David Freeman
Accountable Officer
Somerset Clinical Commissioning Group

Date: 23 May 2019

Annex 1 (Governance Statement)

The member practices of NHS Somerset CCG as at 31 March 2019 are listed below grouped within their Commissioning Locality.

Practice Name	Address
West Somerset	
West Somerset Healthcare	West Somerset Healthcare, Williton Surgery, Robert Street, Williton, Taunton, Somerset, TA4 4QE
Irnham Lodge Surgery	Irnham Lodge Surgery, Townsend Road, Minehead, Somerset, TA24 5RG
Harley House Surgery	Harley House Surgery, 2 Irnham Road, Minehead, Somerset, TA24 5DL
Exmoor Medical Centre	The Exmoor Medical Centre, Oldberry House, Fishers Mead, Dulverton, Exmoor, TA22 9EN
Dunster and Porlock Surgeries	The Surgery Dunster, Knowle Lane, Dunster, Somerset, TA24 6SR and Porlock Medical Centre, Porlock, Somerset, TA24 8PJ
Bridgwater Bay Health	
Quantock Medical Centre	Quantock Medical Centre, Banneson Road, Nether Stowey, Bridgwater, Somerset, TA5 1NW
Cannington Health Centre	Cannington Health Centre, Mill Lane, Cannington, Bridgwater, Somerset, TA5 2HB
East Quay Medical Centre	New East Quay Medical Centre, East Quay, Bridgwater, Somerset, TA6 4GP
Victoria Park Medical Centre	Victoria Park Medical Centre, Victoria Park Drive, Bridgwater, Somerset, TA6 7AS
Taunton Road Medical Centre	Taunton Road Medical Centre, 12-16 Taunton Road, Bridgwater, Somerset, TA6 3LS
Cranleigh Gardens Medical Centre	Cranleigh Gardens Medical Centre, Cranleigh Gardens, Bridgwater, Somerset, TA6 5JS
Redgate Medical Centre	Redgate Medical Centre, Westonzoyland Road, Bridgwater, Somerset, TA6 5BF
Somerset Bridge Medical Centre	Somerset Bridge Medical Centre, Taunton Road, Bridgwater, Somerset, TA6 6LD
North Petherton Surgery	The Surgery, Mill Street, North Petherton, Somerset, TA6 6LX
Polden Medical Practice	Edington Surgery, Quarry Ground, Edington, Bridgwater, Somerset, TA7 9HA and Woolavington Surgery, Woolavington Road, Woolavington TA7 8ED
North Sedgemoor	
Burnham and Berrow Medical Centre	Burnham Medical Centre, Love Lane, Burnham on Sea, Somerset, TA8 1EU
Brent Area Medical Centre	Brent Area Medical Centre, Anvil House, East Brent, Highbridge, Somerset, TA9 4JD
Axbridge and Wedmore Surgeries	Axbridge Surgery, Houlgate Way, Axbridge, BS26 2BJ

Cheddar Medical Centre	Cheddar Medical Centre, Roynon Way, Cheddar, Somerset, BS27 3NZ
Highbridge Medical Centre	Highbridge Medical Centre, Pepperall Road, Highbridge, Somerset, TA9 3YA
West Mendip	
Wells City Practice	Wells City Practice, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Wells Health Centre	Wells Health Centre, Priory Health Park, Glastonbury Road, Wells, Somerset, BA5 1XJ
Glastonbury Surgery	The Glastonbury Surgery, Feversham Lane, Glastonbury, Somerset, BA6 9LP
Glastonbury Health Centre	Glastonbury Health Centre, 1 Wells Road, Glastonbury, Somerset, BA6 9DD
Vine Surgery Partnership	Vine Surgery, Hindhayes Lane, Street, Somerset, BA16 0ET
Central Mendip	
Oakhill Surgery	Oakhill Surgery, Shepton Road, Oakhill, Radstock, Somerset, BA3 5HT
Grove House Surgery	Grove House Surgery, West Shepton, Shepton Mallet, Somerset, BA4 5UH
Park Medical Practice	The Park Medical Practice, Cannards Grave Road, Shepton Mallet, Somerset, BA4 5RT
East Mendip	
Mendip Country Practice	The Mendip Country Practice, Church Street, Coleford, Radstock, Somerset, BA3 5NQ
Beckington Family Practice	The Beckington Family Practice, St Luke's Surgery, Beckington, Frome, Somerset, BA11 6SE
Frome Medical Practice	Frome Medical Practice, Enos Way, Frome, Somerset, BA11 2FH
South Somerset	
Bruton Surgery	The Bruton Surgery, Patwell Lane, Bruton, Somerset, BA10 0EG
Millbrook Surgery	Millbrook Surgery, Millbrook Gardens, Castle Cary, Somerset, BA7 7EE
Wincanton Health Centre	Wincanton Health Centre, Dykes Way, Wincanton, Somerset, BA9 9FQ
Milborne Port Surgery	Milborne Port Surgery, Gainsborough, Milborne Port, Sherborne, Dorset, DT9 5FH
Queen Camel Medical Centre	Queen Camel Medical Centre, West Camel Road, Queen Camel, Yeovil, Somerset, BA22 7LT
Buttercross Health Centre	Buttercross Health Centre, Behind Berry, Somerton, Somerset, TA11 7PB and The Ilchester Surgery, 17 Church Street, Ilchester, Somerset, BA22 8LN
Ryalls Park Medical Centre	Ryalls Park Medical Centre, Marsh Lane, Yeovil, Somerset, BA21 3BA
Oaklands Surgery	Oaklands Surgery, Birchfield Road, Yeovil, Somerset, BA21 5RL
Penn Hill Surgery	Penn Hill Surgery, St Nicholas Close, Yeovil,

	Somerset, BA20 1SB
Diamond Health Group	Hendford Lodge Medical Centre, 74 Hendford, Yeovil, Somerset, BA20 1UJ and Abbey Manor Medical Practice, Abbey Manor Park, Yeovil, Somerset, BA21 3TL
Preston Grove Medical Centre	Preston Grove Medical Centre, Preston Grove, Yeovil, Somerset, BA20 2BQ
West Coker Surgery	Westlake Surgery, High Street, West Coker, Somerset, BA22 9AH
Hamdon Medical Centre	Hamdon Medical Centre, Matts Lane, Stoke Sub Hamdon, Somerset, TA14 6QE
Church Street Surgery	Church Street Surgery, Church Street, Martock, Somerset, TA12 6JL
Crewkerne Health Centre	Crewkerne Health Centre, Middle Path, Crewkerne, Somerset, TA18 8BX
Chard, Crewkerne and Ilminster	
Summervale Medical Centre	Summervale Medical Centre, 1 Wharf Lane, Ilminster, Somerset, TA19 0DT
Essex House Medical Centre	Essex House Medical Centre, 59 Fore Street, Chard, Somerset, TA20 1QA
The Meadows Surgery (Ilminster)	The Meadows Surgery, Canal Way Ilminster, Somerset, TA19 9FE
Springmead Surgery	Springmead Surgery, Summerfields Road, Chard, Somerset, TA20 2EW
Tawstock Medical Centre	Tawstock Medical Centre, 7 High Street, Chard, Somerset, TA20 1QF
Church View Surgery	Church View Surgery, Broadway Road, Broadway, Ilminster, Somerset, TA19 9RX
North Street Surgery (Langport)	The Surgery, North Street, Langport, Somerset, TA10 9RH
Taunton	
North Curry Health Centre	The Health Centre, North Curry, Taunton, Somerset, TA3 6NQ
Creech Medical Centre	Creech Medical Centre, Creech St Michael, Taunton, Somerset, TA3 5QQ
Taunton Vale Healthcare	The Blackbrook Surgery, Lisieux Way, Taunton, Somerset, TA1 2LB
Warwick House Medical Centre	Warwick House Medical Centre, Upper Holway Road, Taunton, Somerset, TA1 2QA
College Way Surgery	College Way Surgery, Taunton, Somerset, TA1 4TY
St James Medical Centre	St James Medical Centre, St James Street, Taunton, Somerset, TA1 1JP
French Weir Health Centre	French Weir Health Centre, French Weir Avenue, Taunton, Somerset, TA1 1NW
Crown Medical Centre	Crown Medical Centre, Venture Way, Taunton, Somerset, TA2 8QY
Lyngford Park Surgery	Lyngford Park Surgery, Fletcher Close, Taunton, Somerset, TA2 8SQ
Quantock Vale Surgery	Quantock Vale Surgery, Mount Street, Bishops Lydeard, Taunton, Somerset, TA4 3LH

Lister House Surgery	Lister House Surgery, Bollams Mead, Wiveliscombe, Somerset, TA4 2PH
Luson Surgery	Luson Surgery, 41 Fore Street, Wellington, Somerset, TA21 8AG
Wellington Medical Centre	Wellington Medical Centre, Mantle Street, Wellington, Somerset, TA21 8BD

Annex 2 (Governance Statement)

Somerset CCG Governing Body Meetings 2018/19 Attendance Record					✓ = Present X = Apologies Given		
(V) = voting Member (NV) = non-voting Member	26.4.18	24.5.18	26.7.18	20.9.18	22.11.18	31.1.19	28.3.19
Dr Ed Ford (V) Chair	✓	✓	✓	✓	✓	✓	✓
Dr Rosie Benneyworth (NV) Director of Strategic Clinical Services Transformation (left CCG 28 February 2019)	✓	✓	✓	✓	✓	✓	
David Bell (V) Non-Executive Director, Lay Member & Chair of the Joint Committee for Commissioning Primary Care (left CCG 30 May 2018)	✓	✓					
Adrian Boyce (V) Interim Chief Operating Officer (from March 2019)							✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓	✓	✓	✓	✓	✓
Sandra Corry (V) Director of Quality and Patient Safety	✓	✓	x	✓	✓	✓	✓
Lou Evans (V) Vice Chair and Non-Executive Director, Lay Member Governance and Audit	✓	✓	✓	✓	✓	✓	✓
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	✓	✓	✓	x	✓	✓
David Freeman (V) Chief Operating Officer (Chief Officer from 1 February 2019)				✓	✓	✓	x
Judith Goodchild (NV) Interim Chair, Healthwatch	X	✓	x	✓	✓	✓	✓
Trudi Grant (V) Director of Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓
Maria Heard (NV) Programme Director Fit for my Future							✓
David Heath (V) Non-Executive Director, Lay Member Patient and Public Engagement	✓	✓	✓	✓	✓	✓	✓
Alison Henly (V) Chief Finance Officer and Director of Performance	✓	✓	x	✓	✓	✓	✓
Dr Alex Murray (V) Governing Body GP	✓	✓	x	✓	x	✓	✓
Deborah Rigby, Deputy Director of Quality, Patient Safety and Engagement (NV – representing Sandra Corry)			✓				
Nick Robinson (V) Chief Officer (left CCG 31 January 2019)	✓	✓	✓	✓	✓	✓	
Sandra Wilson (NV) PPG Lay Observer	✓	✓	x	✓	✓	✓	✓

Somerset CCG Clinical Executive Committee Meetings 2018/19 Attendance Record								✓ = Present X = Apologies Given			
(V) = Voting Member (NV) = Non-Voting Member	11.4.18	9.5.18	13.6.18	11.7.18	5.9.18	3.10.18	7.11.18	5.12.18	9.1.19	6.2.19	6.3.19
Dr Rosie Benneyworth (V) Director of Strategic Clinical Services Transformation	X	✓	✓	X	X	✓	X	X	X	X	
Mr Stephen Chandler (V) Lead Commissioner Adults and Health, Somerset County Council	✓	X	X	X							
Dr Will Chandler (V) Taunton GP Commissioning Locality Delegate	✓	✓	✓	x	✓	✓	✓	X	✓	✓	✓
Mrs Sandra Corry V) Director of Quality and Nursing	X	✓	✓	✓	✓	X	X	✓	✓	✓	✓
Dr Orla Dunn (NV) Consultant in Public Health, Somerset County Council	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Dr Steve Edgar (V) South Somerset Commissioning Locality Delegate (Job Share with Dr Ian Wyer)	X	✓	X	✓	✓	✓	✓	✓	X	X	✓
Dr Ed Ford (V) CCG Chair; and, West Somerset Commissioning Locality Delegate	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Mr David Freeman (V) Chief Officer; and, CEC Chair					X	✓	✓	✓	✓	✓	✓
Dr Will Harris (NV) Clinical Lead: Primary Care						✓	X	X	✓	X	✓
Mrs Maria Heard (V) Programme Director: Fit For My Future											✓
Mrs Alison Henly (V) Director of Finance, Performance and Contracting	X	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Mr Peter Hillman (NV) Lay Members' Representative	✓	✓	X	✓	✓						
Dr Helen Kingston (V) East Mendip Commissioning Locality Delegate	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Mrs Trudi Mann (V) Practice Managers' Delegate	✓	✓	✓								
Dr Alex Murray (V) CEC Vice Chair; and, Bridgwater Bay Health Commissioning Locality Delegate	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Dr Amelia Randle (V) Central and West Mendip Commissioning Localities' Delegate	X	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Mr Nick Robinson (V) CCG Chief Officer; and, CEC Chair	X	✓	X	✓	✓	X	✓	✓	✓		
Dr Kate Staveley (V) CLICK Commissioning Locality Delegate	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Karen Sylvester (NV) LMC Representative	✓	✓	X	X	✓	✓	✓	✓	✓	✓	✓
Dr Helen Thomas (NV) Clinical Lead: Urgent and Emergency Care						✓	✓	X	✓	✓	✓
Mrs Tracey Tilsley (NV) Associate Director of Corporate Business	✓	X	✓	✓	✓	✓	✓	X	X		
Dr Ian Wyer (V) South Somerset Commissioning Locality Delegate (Job Share with Dr Steve Edgar)	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓

Notes:

These meetings were known as Clinical Operations Group meetings until 30 April 2018. They became the Clinical Executive Committee meetings with effect from 1 May 2018

David Freeman joined the CCG in August 2018 as the Chief Operating Officer and became the Chief Officer in February 2019, replacing Nick Robinson who left on 31 January 2019

Maria Heard joined the CCG on 1 March 2019 as Programme Director: Fit For My Future, replacing Rosie Benneyworth who left on 28 February 2019

Somerset CCG Audit Committee Meetings 2018/19 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	16.5.18	19.9.18	12.12.18	21.3.19
Lou Evans Audit Committee Chair and Non-Executive Director, Lay Member (Governance and Audit)	M	✓	✓	✓	✓
David Bell Non-Executive Director, Lay Member (Primary Care) - left CCG 30 May 2018	M	✓	x	x	x
Dr Jayne Chidgey-Clark Non-Executive Director, Registered Nurse	M	✓	✓	✓	✓
Dr Geoff Sharp GP Member	M	✓	✓	✓	✓
Alison Henly Director of Finance, Performance and Contracting	A	✓	✓	✓	x

Notes:

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

Somerset CCG Patient Safety and Quality Assurance Committee Meetings 2018/19 Attendance Record	✓ = Present X = Apologies Given

Name	Member (M)/ In Attendance (A)	18.7.18	17.10.18	12.12.18	13.2.19
Dr Jayne Chidgey-Clark (Chair) Registered Nurse – Governing Body	M	✓	✓	✓	x
Kate Staveley – GP Patient Safety Lead	M	✓	✓	✓	x
Sandra Corry – Director, Quality and Nursing	M	x	x	✓	✓
David Freeman - Chief Operating Officer	M	x	x	x	x
Alison Henly – Director of Finance, Performance and Contracting	M	✓	✓	x	x
Basil Fozard - Non-Executive Director, Secondary Care Specialist Doctor	M				✓
Debbie Rigby – Deputy Director, Quality and Nursing	A	✓	✓	✓	✓
Karen Taylor – Associate Director of Safety and Quality Improvement	A	x	✓	✓	x
Shaun Green – Associate Director Head of Medicines Management and Clinical Effectiveness	A	x	✓	x	x
Jonathan Davies – Quality Lead	A	x	x	x	✓
Dr Andrew Tressider - GP Safety Lead	A	x	✓	✓	✓
Charlotte Brown – Adult Safeguarding Lead Nurse	A	✓	✓	✓	✓
Maria Davis – Designated Nurse Safeguarding Children and Children Looked After	A	✓	✓	x	✓
Mel Munday – Deputy Designated Nurse for Safeguarding Children	A	x	x	✓	x
Jacqui Cross - Infection Prevention and Control Lead Nurse	A	x	x	x	✓
Sarah Ashe - Designated Nurse Safeguarding Looked After Children	A				✓

Somerset CCG Remuneration Committee Meetings 2018/19 Attendance Record	✓ = Present X = Apologies Given

(V) = voting Member (NV) = non-voting Member	11.4.18	31.5.18	18.10.18	20.12.18	31.1.19	13.2.19	28.2.19
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care (left CCG 30 May 2018)	✓						
Lou Evans (V) Remuneration Committee Chair, and CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓ (by phone)	✓	x	x	✓ (by phone)	✓ (by phone)
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	x	✓	✓	✓	✓	✓
David Freeman (NV) Chief Officer from 1 February 2019							✓
David Heath (V) Non-Executive Director, Patient and Public Engagement, and Chair of the Joint Committee for Commissioning Primary Care with effect from 1 June 2018	✓	x	✓	✓	✓	✓ (by phone)	✓
Marianne King (NV) Associate Director of Human Resources and Organisational Development	✓	✓	✓	✓	x	✓	✓
Nick Robinson (NV) Chief Officer (left CCG 31 January 2019)	✓	✓	x	x			

Notes:

Dr Ed Ford attended all meetings (NV capacity) with the exception of 31 May 2018.

Judith Dean and Pat Flaherty attended the meeting on 31 January 2019 (NV).

Alison Henly attended the meeting on 28 February 2019 (NV).

Somerset CCG Primary Care Joint Committee Meetings 2018/19 Attendance Record	✓ = Present X = Apologies Given

(M) Committee member (A) In attendance	Committee Role (eg. Executive, Lay, GP, etc)	6.6.18	6.9.18	6.12.18	14.3.19
David Health (M)	Chair, Non-Executive Director	X	✓	✓	✓
Lou Evans (M)	Vice Chair (Until September 2018), Non-Executive Director	✓	X		
David Freeman (M)	Chief Operating Officer, CCG			X	
Alison Henly (M)	Director of Finance, Performance and Contracting, CCG	✓	✓	✓	✓
Sandra Corry (M)	Director of Quality and Nursing, CCG	✓	✓	X	X
Sharon Wilson (M)	Interim Head of Primary Care, NHS E			✓	✓
Laila Pennington (M)	Head of Primary Care, NHS E	X	X		
Amanda Fisk (M)	Director of Assurance and Delivery, NHS E	✓	✓	✓	X
Louise Woolway (M) / Trudi Grant (from March 19)	Public Health, SCC	X	✓	✓	✓
Dr Basil Fozard (M)	Vice Chair (Started December 2018), Non-Executive Director	X	✓	✓	✓
Dr Will Harris (M)	GP Clinical Lead, CCG	✓	✓	✓	✓
John Burrows (M)	Assistant Head of Finance (Primary Care) / Associate Director of Finance – Projects, NHS E / CCG (Dec onwards)	✓	✓	✓	✓
Kevin Davis (M)	Acting Director of Finance, NHS E	✓	X	✓	X
Dr Chris Campbell (M)	External GP	X	✓	X	X
Martin Davidson (M)	PPG Chair Rep	✓	✓	X	✓
Dr Nick Bray (M)	LMC Representative	X	X	✓	X
Dr Kate Staveley (M)	GP	✓	X		
Tariq White (M)	Associate Director, NHS England	X	X		
Judith Goodchild (M)	Chair of the Board, Healthwatch	X	✓	✓	✓
Tanya Whittle (A) / (M)	Deputy Director of Contracting, CCG	✓	✓	X	✓
Michael Bainbridge (A) / (M)	Associate Director of Primary Care, CCG	✓	X	✓	✓
Karen Taylor (A) / (M)	Associate Director of Safety and Quality Improvement, CCG	✓	X	✓	✓
Dr Rosie Benneyworth (M)	Director of Strategic Clinical Services Transformation, CCG	X	X		
Carol Ogilvie	Senior Finance Manager, NHS E		✓	X	✓
Dr Barry Moyse (Attended on behalf of Dr Nick Bray LMC) (A)	LMC	✓			

Somerset CCG Finance and Performance Committee Meetings 2018/19 Attendance Record	✓ = Present X = Apologies Given

Name	20.6.18	27.7.18	29.8.18	11.10.18	13.11.18	12.12.18	16.1.19	13.2.19	13.3.19
Nick Robinson Chief Officer (left CCG 31 January 2019)	X	✓	✓	✓	✓	✓	✓	X	X
Lou Evans Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ed Ford CCG Chair	X	X	✓	✓	X	✓	✓	✓	✓
David Freeman Chief Operating Officer (Chief Officer from 1 February 2019)			X	X	X	X	✓	✓	✓
Alison Henly Director of Finance, Performance and Contracting	✓	✓	✓	✓	✓	✓	✓	✓	X
Sandra Corry Director of Quality and Nursing	X	X	✓	✓	✓	X	✓	✓	X

Remuneration and Staff Report

8. Remuneration Report

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

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.

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.

The remuneration report and following disclosures in the Accountability Report on pages 100-114 have been audited by Grant Thornton UK LLP, Somerset CCG's external auditors.

- Disclosures on Parliamentary accountability
- Single total figure of remuneration for each director
- CETV disclosures for each director
- Payments to past directors
- Payments for loss of office
- "fair pay" (pay multiples)
- Exit packages
- Analysis of staff numbers and costs.

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

8.1. Senior manager remuneration (including salary and pension entitlements)

		Total 2018/19						Total 2017/18					
		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 £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)	(rounded to the nearest £100)	(bands of £5,000)	(bands of £5,000)	(bands of £2,500)	(bands of £5,000)
		£'000	£'00	£'000	£'000	£'000	£'000	£'000	£'00	£'000	£'000	£'000	£'000
Nick Robinson	Chief Officer (left 31/1/19)	125-130	0	0	0	0	125-130	95-100	0	0	0	0	95-100
David Freeman	Chief Officer (from 1/2/19) and CEC Chair / Chief Operating Officer	80-85	0	0	0	40-42.5	120-125	-	-	-	-	-	-
Adrian Boyce	Interim Chief Operating Officer	10-15	0	0	0	0	10-15	-	-	-	-	-	-
Alison Henly	Director of Finance, Performance and Contracting	105-110	57	0	0	47.5-50	165-170	100-105	60	0	0	17.5-20	125-130
Rosie Benneyworth	Director of Strategic Clinical Services Transformation	100-105	0	0	0	35-37.5	135-140	50-55	0	0	0	57.5-60	105-110
Maria Heard	Programme Director of Fit for My Future	5-10	0	0	0	22.5-25	30-35	-	-	-	-	-	-
Sandra Corry	Director of Quality and Nursing	90-95	0	0	0	5-7.5	95-100	90-95	0	0	0	50-52.5	140-145
Edward Ford	Chair	80-85	0	0	0	15-17.5	95-100	75-80	0	0	0	27.5-30	105-110

Alex Murray	Fit for My Future Clinical Lead and CEC Vice Chair	85-90	0	0	0	17.5-20	105-110	60-65	0	0	0	122.5-125	185-190
David Bell	Non Exec Director	0-5	0	0	0	0	0-5	10-15	0	0	0	0	10-15
Lou Evans	Lay Member (Vice-Chair)	35-40	0	0	0	0	35-40	35-40	0	0	0	0	35-40
David Heath	Non Exec Director	10-15	0	0	0	0	10-15	5-10	0	0	0	0	5-10
Basil Fozard	Secondary Care Doctor	5-10	0	0	0	0	5-10	5-10	0	0	0	0	5-10
Dr Jayne Chidgey-Clark	Registered Nurse	15-20	0	0	0	0	15-20	15-20	0	0	0	0	15-20

Officer Holder Changes:

Nick Robinson retired on 31 January 2019, however was paid in lieu of notice until 30 April 2019 (£39k). This exit package payment is not included within the table above but is reflected within the exit packages section in the staff report.
David Freeman was appointed to the post of Chief Operating Officer from 1 August 2018 and has been Interim Chief Officer since the retirement of Nick Robinson on 31 January 2019.
Adrian Boyce was appointed as the Interim Chief Operating Officer from 4 March 2019. This appointment is via an external agency, for which fees of £9k were payable in addition to the remuneration reported in the table above.
Dr Rosie Benneyworth resigned from the post of Director of Strategic Clinical Services Transformation on 1 March 2019.
Maria Heard was appointed to the post of Programme Director for the Fit for My Future Programme on 1 March 2019. This appointment is a secondment from the South Central and West Commissioning Support Unit (SCWCSU).
Dr Alex Murray was appointed to the post of Clinical Lead for the Fit for My Future Programme in March 2019.
David Bell resigned from the post of Non-Executive Director in May 2018

Other Notes:
A Somerset Sustainability and Transformation 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 2018/19.

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

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.

8.2. Pension benefits as at 31 March 2019

Name	Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at Pension age at 31 March 2019	Lump sum at pension age related to accrued pension at 31 March 2019	Cash equivalent transfer value at 1 April 2018	Real increase in cash equivalent transfer value	Cash equivalent transfer value at 31 March 2019	Employer's contribution to partnership pension
		(bands of £2,500)	(bands of £2,500)	(bands of £5,000)	(bands of £5,000)				
		£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
David Freeman	Chief Officer	0-2.5	0-2.5	25-30	60-65	359	45	454	0
Alison Henly	Director of Finance, Performance and Contracting	2.5-5	2.5-5	35-40	90-95	555	109	695	0
Maria Heard	Programme Director of Fit for My Future	0-2.5	0	10-15	0-5	83	2	119	0
Sandra Corry	Director of Quality and Nursing	0-2.5	0-2.5	35-40	110-115	755	83	874	0
Rosie Benneyworth *	Director of Strategic Clinical Services Transformation	0-2.5	0	10-15	20-25	143	29	195	0
Edward Ford *	Chair	0-2.5	0	5-10	0	41	9	63	0
Alex Murray *	Fit for My Future Clinical Lead and CEC Vice Chair	0-2.5	0	5-10	10-15	95	20	131	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. This is applicable to the individuals indicated (*).

8.3. Cash equivalent transfer values

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

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

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

8.4. Real Increase in CETV

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

8.5. Compensation on early retirement of for loss of office

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

8.6. Payments to past members

The Clinical Commissioning Group has made no payments to past directors during 2018/19.

8.7. Pay multiples

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

The banded remuneration of the highest paid director in NHS Somerset CCG in the financial year 2018/19 was £130,000 (2017/18: £156,000). This was 4.00 times (2017/18: 4.6) the median remuneration of the workforce, which was £32,525 (2017/18: £33,895). In 2018/19, zero employees received remuneration in excess of the highest-paid director/Member. Remuneration ranged from £11,808 to £130,000 (2017/18: £10,796 to £156,000).

The former Chief Officer of the CCG retired from office on 31 January 2019 but was paid in lieu of notice until 30 April 2019. This exit package payment is reflected within the tables included in the staff report at section 9.10 of this report.

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.

8.8. 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 2018 to 31 March 2019.
Cash Equivalent Transfer Value (CETV)	A CETV is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated in accordance with the Occupational Pension Schemes (Transfer Values) Regulations 2008.
Employer's contribution to stakeholder pension	The amount that the Clinical Commissioning Group has contributed to individual's stakeholder pension schemes.
Lump sum at pension age related to real increase in pension	The amount by which the lump sum to which an individual will be entitled on retirement has increased during the year
Lump sum at pension age related to accrued pension at 31 March 2019	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 2019
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 2019	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 2019

8.9. Remuneration of the Chief Officer and Directors

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

The membership and attendance at the Somerset CCG Remuneration Committee during 2018/19 is set out below:

Somerset CCG Remuneration Committee Meetings 2018/19 Attendance Record				✓ = Present X = Apologies Given			
(V) = voting Member (NV) = non-voting Member	11.04.18	31.05.18	18.10.18	20.12.18	31.01.19	13.02.19	28.02.19
David Bell (V) Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care (left CCG on 30.5.18)	✓						
Lou Evans (V) Remuneration Committee Chair, and CCG Vice Chair and Non-Executive Director, Governance and Audit	✓	✓	✓	✓	✓	✓	✓
Dr Jayne Chidgey-Clark (V) Non-Executive Director, Registered Nurse	✓	✓ (by phone)	✓	x	x	✓ (by phone)	✓ (by phone)
Basil Fozard (V) Non-Executive Director, Secondary Care Specialist Doctor	✓	x	✓	✓	✓	✓	✓
David Freeman (NV) Chief Officer from 1 February 2019							✓
David Heath (V) Non-Executive Director, Patient and Public Engagement, and Chair of the Joint Committee for Commissioning Primary Care with effect from 1 June 2018	✓	x	✓	✓	✓	✓ (by phone)	✓
Marianne King (NV) Associate Director of Human Resources and Organisational Development	✓	✓	✓	✓	x	✓	✓
Nick Robinson (NV) Chief Officer (left CCG 31 January 2019)	✓	✓	x	x			
Note: No additional persons attended the Committee in order to provide legal advice on compliance with any relevant legislation.							

8.10. Policy on Remuneration of Senior Managers

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 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.

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

8.11. Policy on Contracts

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

9. Staff Report

9.1. Number of senior managers

The number of senior managers is set out below in paragraph 9.4.

9.2. Staff numbers and costs

The Somerset CCG's total staff costs for the year ended 31 March 2019 are summarised in the following table:

	Total		
	Permanent Employees £'000	Other £'000	Total £'000
	N4G	N4H	N4I
Salaries and wages	7,645	689	8,334
Social security costs	825	24	849
Employer contributions to the NHS Pension Scheme	1,006	29	1,035
Other pension costs	1	-	1
Apprenticeship levy	27	-	27
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	240	-	240
Gross Employee Benefits Expenditure	**9,744**	**742**	**10,486**
Less: Recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Net employee benefits expenditure incl. capitalised costs	**9,744**	**742**	**10,486**
Less: Employee costs capitalised	-	-	-
Net employee benefits expenditure excl. capitalised costs	**9,745**	**741**	**10,486**

9.3. Average Number of Persons Employed

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

Average number of people employed				
			2018/19	2017/18
	Permanently employed	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	6	0	6	5
Administration and estates	129	7	132	122
Healthcare assistants and other support staff	1	0	1	0
Nursing, midwifery and health visiting staff	53	0	53	40
Scientific, therapeutic and technical staff	0	0	0	4
Social Care Staff	2	0	2	1
Total	**191**	**7**	**198**	**172**
Of the above:				
Number of whole time equivalent people engaged on capital projects	-	-	-	-

The average number of employees has increased since 2017/18 due to a staffing restructure that took place during the year.

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.

9.4. Staff composition

The breakdown of the gender profile for the CCG as at the end of March 2019 is set out below:

Category	% Male	% Female	Total Number
Governing Body Voting Members	55%	45%	11
Membership Body Clinical Executive Committee Voting Members	36%	64%	11
Very Senior Managers	50%	50%	4
All substantive CCG Staff	14%	76%	216

9.5. Trade Union Facility Time

The trade union (facility time publication requirements) regulations 2017 came in to force on 1 April 2017.

In line with these new regulations, all organisations employing more than 49 staff, must publish information on facility time, which is agreed time off from an individual's job to carry out a trade union role.

Our organisation
Somerset Clinical Commissioning Group
1 April 2018 to 31 March 2019

Employees in our organisation
50 to 1,500 employees

Trade union representatives and full-time equivalents
Trade union representatives: 0
FTE trade union representatives: 0

Percentage of working hours spent on facility time
0% of working hours: 0 representatives
1 to 50% of working hours: 0 representatives
51 to 99% of working hours: 0 representatives
100% of working hours: 0 representatives

Total pay bill and facility time costs
Total pay bill: £10,486,000
Total cost of facility time: £0
Percentage of pay spent on facility time: 0.00%

Paid trade union activities
Hours spent on paid facility time: 0
Hours spent on paid trade union activities: 0
Percentage of total paid facility time hours spent on paid TU activities: 0%

9.6. Sickness absence data and ill health retirements

Staff sickness absence and ill health retirements **Full Time Equivalent**	**2018/19 Number**	**2017/18 Number**
Total Days Lost	2,320	1,684
Total Days Available	68,011	58,642
Average working Days Lost	7.7	6.5
Average FTE	186	161
Number of persons retiring on ill health grounds (Ill Health Retirement costs are met by the NHS Pension Scheme)	1	0

2018/19 staff sickness values are based on a 12 month period covering the calendar year of 2018. 2017/18 staff sickness values are based on a 12 month period covering the calendar year of 2017.

The CCG has a clear and robust Management of Sickness Absence Policy.

9.7. Staff Policies

The Clinical Commissioning Group has applied the following new or updated staff policies in 2018/19:

The Absence Management Policy
The Health and Wellbeing Policy
The Induction Policy
The Organisational Change Policy
The Pay Progression Policy
The Secondment Policy
The Staff Retention Policy
The Whistleblowing Policy
The Work Experience Policy

9.8. Expenditure on consultancy

The Clinical Commissioning Group consultancy expenditure in 2018/19 was £128,000 (2017/18 £820,000), as per note 5 in the annual accounts.

9.9. Off-payroll engagements

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

Table 1: Off-payroll engagements longer than 6 months

	Number
Number of existing engagements as of 31 March 2019	16
Of which, the number that have existed:	
for less than one year at the time of reporting	8
for between one and two years at the time of reporting	1
for between 2 and 3 years at the time of reporting	3
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	4

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.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than 6 months.

Table 2: New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	8
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	8
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

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

Table 3: 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	2
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements.	13

During the year there have been two incidences where senior officer positions have been held by off-payroll members of staff. This includes the current Interim Chief Operating Officer and the current 'Fit For My Future' Programme Director.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the position of Chief Operating Officer. The requirement was for a short term appointment, for a period of approximately 6 months, and there was a requirement for the individual to be in post as soon as possible due to the scope and influence of the role of Chief Operating Officer. An off-payroll member of staff was able to deliver high quality work for a short term appointment without significant delays of recruiting traditionally to the post.

It was considered that there was not sufficient capacity or capability within the organisation to provide cover for the position of Programme Director for the Fit For My Future Programme. The post is a fixed term appointment for one year, and there was a requirement for the individual to be in post as soon as possible to ensure that the impetus of the project was maintained after the resignation of the previous post holder. An off-payroll member of staff was available with the relevant skills to deliver high quality work without significant delays of recruiting traditionally to the post.

9.10. Exit packages, including special (non-contractual) payments

Redundancy and other departure cost have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook and are in line with statutory requirements. Exit costs in this note are accounted for in full in the year of departure. Where Somerset CCG has agreed early retirements, the additional costs are met by 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 below.

Table 1: 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	2	19,890	2	19,890	0	0
£10,000 - £25,000	0	0	1	21,333	1	21,333	0	0
£25,001 - £50,000	0	0	1	39,000*	1	39,000*	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	1	160,000	0	0	1	160,000	0	0
>£200,000	0	0	0	0	0	0	0	0
TOTALS	**1**	**160,000**	**4**	**80,223**	**5**	**240,223**	**0**	**0**

*The officer holder information is included in note 8.1.Senior manager remuneration.

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 in Table 2 below will not necessarily match the total numbers in Table 1 above, which will be the number of individuals.

Table 2: 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*	4	80,223
Exit payments following Employment Tribunals or court orders	0	0
Non-contractual payments requiring HMT approval**	0	0
TOTAL	**4**	**80,223**

*any non-contractual payments in lieu of notice are disclosed under “non-contracted payments requiring HMT approval” below.
**includes any non-contractual severance payment made following judicial mediation and non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit packages payable to Senior managers named in the Report.

Parliamentary Accountability and Audit Report

NHS Somerset CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report at **Appendix 1**. An audit certificate and report is also included in this Annual Report at **Appendix 2**.

ANNUAL ACCOUNTS

David Freeman

Accountable Officer

23 May 2019

Appendix 1 NHS Somerset CCG – Annual Accounts 2018-19

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

NHS Somerset CCG - Annual Accounts 2018-19

Entity name:	NHS Somerset CCG
This year	2018-19
Last year	2017-18
This year ended	31-March-2019
Last year ended	31-March-2018
This year commencing:	01-April-2018
Last year commencing:	01-April-2017

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The Primary Statements:

Notes to the Accounts

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

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	2	(1,839)	(2,480)
Other operating income	2	(1,408)	(4,374)
Total operating income		**(3,247)**	**(6,854)**
Staff costs	4	10,486	9,147
Purchase of goods and services	5	752,728	734,029
Depreciation and impairment charges	5	96	88
Provision expense	5	1,541	225
Other Operating Expenditure	5	183	477
Total operating expenditure		**765,034**	**743,966**
Net Operating Expenditure		**761,787**	**737,112**
Finance income		-	-
Finance expense		-	-
Net expenditure for the year		**761,787**	**737,112**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**761,787**	**737,112**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	**-**
Comprehensive Expenditure for the year		**761,787**	**737,112**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	13	280	321
Intangible assets	14	5	9
Investment property	15	-	-
Trade and other receivables	17	-	-
Other financial assets	18	-	-
Total non-current assets		**285**	**330**
Current assets:			
Inventories	16	2	2
Trade and other receivables	17	4,484	7,625
Other financial assets	18	-	-
Other current assets	19	-	-
Cash and cash equivalents	20	48	71
Total current assets		**4,534**	**7,698**
Non-current assets held for sale	21	-	-
Total current assets		**4,534**	**7,698**
Total assets		**4,819**	**8,028**
Current liabilities			
Trade and other payables	23	(42,800)	(45,303)
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	(1,555)	(722)
Total current liabilities		**(44,355)**	**(46,025)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(39,536)**	**(37,997)**
Non-current liabilities			
Trade and other payables	23	-	-
Other financial liabilities	24	-	-
Other liabilities	25	-	-
Borrowings	26	-	-
Provisions	30	-	-
Total non-current liabilities		**-**	-
Assets less Liabilities		**(39,536)**	**(37,997)**
Financed by Taxpayers' Equity			
General fund		(39,536)	(37,997)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(39,536)**	**(37,997)**

The notes on pages 5 to 40 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 23 May 2019 and signed on its behalf by:

David Freeman
Accountable Officer
NHS Somerset Clinical Commissioning Group

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

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2018-19				
Balance at 01 April 2018	(37,997)	0	0	**(37,997)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Impact of applying IFRS 9 to Opening Balances	0			**0**
Impact of applying IFRS 15 to Opening Balances	0			**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2018	**(37,997)**	**0**	**0**	**(37,997)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2018-19				
Net operating expenditure for the financial year	(761,787)			**(761,787)**
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**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			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	**(761,787)**	**0**	**0**	**(761,787)**
Net funding	760,248	0	0	**760,248**
Balance at 31 March 2019	**(39,536)**	**0**	**0**	**(39,536)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2017-18				
Balance at 01 April 2017	(29,839)	0	0	**(29,839)**
Transfer 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 2018	**(29,839)**	**0**	**0**	**(29,839)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2017-18				
Net operating costs for the financial year	(737,112)			(737,112)
Net gain/(loss) on revaluation of property, plant and equipment		0		0
Net gain/(loss) on revaluation of intangible assets		0		0
Net gain/(loss) on revaluation of financial assets		0		0
Total revaluations against revaluation reserve		**0**		**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(737,112)**	**0**	**0**	**(737,112)**
Net funding	728,954	0	0	728,954
Balance at 31 March 2018	**(37,997)**	**0**	**0**	**(37,997)**

The notes on pages 5 to 40 form part of this statement

Statement of Cash Flows for the year ended 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(761,787)	(737,112)
Depreciation and amortisation	5	96	88
Impairments and reversals	5	0	0
Non-cash movements arising on application of new accounting standards		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	3,140	59
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	23	(2,503)	8,125
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	30	(708)	(283)
Increase/(decrease) in provisions	30	1,541	225
Net Cash Inflow (Outflow) from Operating Activities		**(760,221)**	(728,898)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(50)	(34)
(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
Non-cash movements arising on application of new accounting standards		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		**(50)**	(34)
Net Cash Inflow (Outflow) before Financing		**(760,271)**	(728,932)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		760,248	728,954
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
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**760,248**	728,954
Net Increase (Decrease) in Cash & Cash Equivalents	20	**(23)**	22
Cash & Cash Equivalents at the Beginning of the Financial Year		**71**	49
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		**48**	71

The notes on pages 5 to 40 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis**.**
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
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 **Movement of Assets within the Department of Health and Social Care Group**

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

1.4 **Subsidiaries**

Somerset Clinical Commissioning Group does not have any subsidiaries.

1.5 **Associates**

Somerset Clinical Commissioning Group does not have any associates.

1.6 **Joint arrangements**

Somerset Clinical Commissioning Group does not have any joint arrangements except for the pooled budgets below.

1.7 **Pooled Budgets**

NHS Somerset Clinical Commissioning Group has entered into a pooled budget arrangement with Somerset County Council (in accordance with section 75 of the NHS Act 2006). Under the arrangement, funds are pooled for learning disability services, community equipment services, carers services and the Better Care Fund and a memorandum note to the accounts provides details of the income and expenditure.

The pool is hosted by Somerset County Council. 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

1.8 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Clinical Commissioning Group.

1.9 **Revenue**

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.
Somerset Clinical Commissioning Group considers that it does not have any revenue sources to which application of the Standard would have any material impact to the way that it has historically been reported.
In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;
• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.
Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.
Payment terms are within fourteen days of invoice date.

The value of the benefit received when the Clinical Commissioning Group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

Notes to the financial statements

1.10 **Employee Benefits**

1.10.1 **Short-term Employee Benefits**

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

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

1.10.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Local Government Pensions

None of Somerset Clinical Commissioning Group's employees are members of the Local Government Pension Scheme (LGPS), which is a defined benefit pension scheme.

1.11 **Other Expenses**

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

1.12 **Grants Payable**

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

1.13 **Property, Plant & Equipment**

1.13.1 **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.

1.13.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date

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

1.14 **Intangible Assets**

1.14.1 **Recognition**

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

· When it is probable that future economic benefits will flow to, or service potential be provided to, the Clinical Commissioning Group;

· Where the cost of the asset can be measured reliably; and,
· Where the cost is at least £5,000.

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

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

Notes to the financial statements

1.14.2 **Measurement**

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

1.14.3 **Depreciation, Amortisation & Impairments**

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

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

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.
A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.15 **Donated Assets**

Somerset Clinical Commissioning Group does not have any donated assets.

1.16 **Government grant funded assets**

Government grant funded assets are capitalised at current value in existing use, if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

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

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

1.18 **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.

1.18.1 **The Clinical Commissioning Group as Lessee**

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.18.2 **The Clinical Commissioning Group as Lessor**

Somerset Clinical Commissioning Group does not have any lessor arrangements.

1.19 **Private Finance Initiative Transactions (PFI)**

Somerset Clinical Commissioning Group does not have any PFI schemes.

1.20 **Inventories**

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

1.21 **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.

1.22 **Provisions**

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

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

Notes to the financial statements

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.
All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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

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

1.23 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the Clinical Commissioning Group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Clinical Commissioning Group.

1.24 **Non-clinical Risk Pooling**
The Clinical Commissioning Group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Clinical Commissioning Group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.25 **Carbon Reduction Commitment Scheme**
The Carbon Reduction Commitment scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Clinical Commissioning Group is not registered with the CRC scheme.

1.26 **Contingent liabilities and contingent assets**

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

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.27 **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 amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.27.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.27.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.27.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

Notes to the financial statements

1.27.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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.

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 pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Somerset Clinical Commissioning Group does not have any exposure to foreign currencies.

1.31 **Third Party Assets**

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

1.32 **Losses & Special Payments**

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

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

1.33 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Clinical Commissioning Group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.33.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Clinical Commissioning Group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- Provisions recognised as at 31 March 2019 – note 30
- Income and expenditure accruals – note 23

1.34 **Gifts**

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

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

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

● IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

● IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

An impact assessment for the adoption of IFRS 16 has been submitted to NHS England by the Clinical Commissioning Group. The current estimated impact is an additional operating lease liability of approximately £23k in 2019/20,

IFRS 17 and IFRIC 23 are still under consideration and no assessment of impact has been evaluated to date.

2 Other Operating Revenue

	2018-19 Total	2017-18 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	**714**	871
Non-patient care services to other bodies	**1,125**	1,609
Patient transport services	**-**	-
Prescription fees and charges	**-**	-
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**-**	-
Recoveries in respect of employee benefits	**-**	-
Total Income from sale of goods and services	**1,839**	**2,480**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**5**	2
Other non contract revenue	**1,403**	4,372
Total Other operating income	**1,408**	**4,374**
Total Operating Income	**3,247**	**6,854**

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

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Source of Revenue								
NHS	639	112	-	-	-	-	-	-
Non NHS	75	1,013	-	-	-	-	-	-
Total	**714**	**1,125**	**-**	**-**	**-**	**-**	**-**	**-**

	Education, training and research	Non-patient care services to other bodies	Patient transport services	Prescription fees and charges	Dental fees and charges	Income generation	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Timing of Revenue								
Point in time	714	1,125	-	-	-	-	-	-
Over time	-	-	-	-	-	-	-	-
Total	**714**	**1,125**	**-**	**-**	**-**	**-**	**-**	**-**

3.2 Transaction price to remaining contract performance obligations

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

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

4. Employee benefits and staff numbers

4.1.1 Employee benefits

Total 2018-19

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	**7,645**	**689**	**8,334**
Social security costs	**825**	**24**	**849**
Employer Contributions to NHS Pension scheme	**1,006**	**29**	**1,035**
Other pension costs	**1**	**-**	**1**
Apprenticeship Levy	**27**	**-**	**27**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**240**	**-**	**240**
Gross employee benefits expenditure	9,744	742	10,486
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	9,744	742	10,486
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	9,744	742	10,486

4.1.1 Employee benefits

Total 2017-18

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

4.1.2 Recoveries in respect of employee benefits

	Permanent Employees £'000	Other £'000	2018-19 Total £'000	2017-18 Total £'000
Employee Benefits - Revenue				
Salaries and wages	**-**	**-**	**-**	**-**
Social security costs	**-**	**-**	**-**	**-**
Employer contributions to the NHS Pension Scheme	**-**	**-**	**-**	**-**
Other pension costs	**-**	**-**	**-**	**-**
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	-	-	-	-

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**191**	**7**	**198**	**169**	**3**	**172**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.4 Exit packages agreed in the financial year

	2018-19 Compulsory redundancies		2018-19 Other agreed departures		2018-19 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	2	19,890	2	19,890
£10,001 to £25,000	-	-	1	21,333	1	21,333
£25,001 to £50,000	-	-	1	39,000	1	39,000
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	1	160,000	-	-	1	160,000
Over £200,001	-	-	-	-	-	-
Total	**1**	**160,000**	**4**	**80,223**	**5**	**240,223**

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

	2018-19 Departures where special payments have been made		2017-18 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	2018-19 Other agreed departures		2017-18 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	4	80,223	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**4**	**80,223**	**-**	**-**

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

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Terms and Conditions of Service Handbook and are in line with statutory requirements.

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

Where NHS Somerset CCG has agreed early retirements, the additional costs are met by NHS Somerset CCG and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

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

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

Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

4.5.2 Full actuarial (funding) valuation

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

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

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

For 2018-19, employers' contributions of £1,026,686 were payable to the NHS Pensions Scheme (2017-18: £894,552) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on 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 2012. These costs are included in the NHS pension line of note 4.1.1

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	4,593	3,840
Services from foundation trusts	503,812	487,778
Services from other NHS trusts	24,761	24,859
Provider Sustainability Fund (Sustainability Transformation Fund 1718)	-	-
Services from Other WGA bodies	34	35
Purchase of healthcare from non-NHS bodies	88,304	87,215
Purchase of social care	34,398	33,291
General Dental services and personal dental services	-	-
Prescribing costs	78,909	81,040
Pharmaceutical services	-	-
General Ophthalmic services	540	545
GPMS/APMS and PCTMS	9,707	8,109
Supplies and services – clinical	-	-
Supplies and services – general	2,272	1,519
Consultancy services	128	820
Establishment	801	524
Transport	2,683	2,467
Premises	826	682
Audit fees [1]	63	63
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	-
Other professional fees	122	50
Legal fees	132	166
Education, training and conferences	643	1,026
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Total Purchase of goods and services	**752,728**	**734,029**
Depreciation and impairment charges		
Depreciation	92	84
Amortisation	4	4
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets		
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**96**	**88**
Provision expense		
Change in discount rate	-	-
Provisions	1,541	225
Total Provision expense	**1,541**	**225**
Other Operating Expenditure		
Chair and Non Executive Members	170	185
Grants to Other bodies	-	259
Clinical negligence	8	7
Research and development (excluding staff costs)	-	24
Expected credit loss on receivables	-	-
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Non cash apprenticeship training grants	5	2
Other expenditure	-	-
Total Other Operating Expenditure	**183**	**477**
Total operating expenditure	**754,548**	**734,819**

Notes

1. External Audit Fees Net of Vat total £52,500.
2. Grant Thornton UK LLP also had non audit fees of £10,000 for audit related assurance service
3. The auditor's liability for external audit work carried out for the financial year 2018/19 is limited to £2,000,000.

6.1 Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	9,794	129,156	12,272	124,745
Total Non-NHS Trade Invoices paid within target	9,754	128,637	12,248	124,265
Percentage of Non-NHS Trade invoices paid within target	**99.59%**	**99.60%**	**12,248**	**124,265**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,406	538,557	3,396	512,129
Total NHS Trade Invoices Paid within target	3,401	538,171	3,387	511,760
Percentage of NHS Trade Invoices paid within target	**99.85%**	**99.93%**	**99.73%**	**99.93%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2018-19 £'000**	2017-18 £'000
Amounts included in finance costs from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-
Total	**-**	**-**

7 Income Generation Activities

The Clinical Commissioning Group did not have any income generation activities in 2018-19.

8. Investment revenue

The Clinical Commissioning Group did not have any Investment Revenue as at 31 March 2019.

9. Other gains and losses

The Clinical Commissioning Group did not have any other gains and losses as at 31 March 2019.

10.1 Finance costs

The Clinical Commissioning Group did not have any Finance Costs as at 31 March 2019.

10.2 Finance income

The Clinical Commissioning Group did not have any Finance income as at 31 March 2019.

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 2019.

12. Operating Leases

12.1 As lessee

The Clinical Commissioning Group occupies property owned and managed by NHS Property Services Ltd. In 2018-19 the charge to the Clinical Commissioning Group included 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

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payments recognised as an expense								
Minimum lease payments	-	750	14	**764**	-	666	24	**690**
Contingent rents	-	-	-	**-**	-	-	-	**-**
Sub-lease payments	-	-	-	**-**	-	-	-	**-**
Total	**-**	**750**	**14**	**764**	**-**	**666**	**24**	**690**

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

12.1.2 Future minimum lease payments

	2018-19				2017-18			
	Land	**Buildings**	**Other**	**Total**	**Land**	**Buildings**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Payable:								
No later than one year	-	-	17	**17**	-	-	20	**20**
Between one and five years	-	-	19	**19**	-	-	6	**6**
After five years	-	-	-	**-**	-	-	-	**-**
Total	**-**	**-**	**36**	**36**	**-**	**-**	**26**	**26**

12.2 As lessor

The Clinical Commissioning Group did not have any leases let as at 31 March 2019.

13 Property, plant and equipment

2018-19	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 2018	-	-	-	-	-	-	505	119	624
Addition of assets under construction and payments on account				-					-
Additions purchased	-	-	-	-	-	-	50	-	50
Additions donated	-	-	-	-	-	-	-	-	-
Additions government granted	-	-	-	-	-	-	-	-	-
Additions leased	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Cost/Valuation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**555**	**119**	**674**
Depreciation 01 April 2018	-	-	-	-	-	-	270	32	302
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-	-	-	-	-	-
Disposals other than by sale	-	-	-	-	-	-	-	-	-
Upward revaluation gains	-	-	-	-	-	-	-	-	-
Impairments charged	-	-	-	-	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Charged during the year	-	-	-	-	-	-	76	16	92
Transfer (to)/from other public sector body	-	-	-	-	-	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-	-	-	-	-	-
Depreciation at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**346**	**48**	**394**
Net Book Value at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**209**	**71**	**280**
Purchased	-	-	-	-	-	-	209	71	280
Donated	-	-	-	-	-	-	-	-	-
Government Granted	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**209**	**71**	**280**
Asset financing:									
Owned	-	-	-	-	-	-	209	71	280
Held on finance lease	-	-	-	-	-	-	-	-	-
On-SOFP Lift contracts	-	-	-	-	-	-	-	-	-
PFI residual: interests	-	-	-	-	-	-	-	-	-
Total at 31 March 2019	**-**	**-**	**-**	**-**	**-**	**-**	**209**	**71**	**280**

Revaluation Reserve Balance for Property, Plant & Equipment

The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2019.

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 2019.

13.2 Donated assets
The Clinical Commissioning Group did not hold any donated assets at 31 March 2019.

13.3 Government granted assets
The Clinical Commissioning Group did not hold any government granted assets at 31 March 2019.

13.4 Property revaluation
The Clinical Commissioning Group did not have any property revaluations at 31 March 2019.

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 2019.

13.6 Write downs to recoverable amount
The Clinical Commissioning Group did not have any assets written down to recoverable amounts at 31 March 2019.

13.7 Temporarily idle assets
The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2019.

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 2019.

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

2018-19	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 2018	20	-	-	-	-	**20**
Additions purchased	-	-	-	-	-	**-**
Additions internally generated	-	-	-	-	-	**-**
Additions donated	-	-	-	-	-	**-**
Additions government granted	-	-	-	-	-	**-**
Additions leased	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	**-**
Transfer (to)/from other public sector body	-	-	-	-	-	**-**
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	**-**
Cost / Valuation At 31 March 2019	**20**	**-**	**-**	**-**	**-**	**20**
Amortisation 01 April 2018	11	-	-	-	-	**11**
Reclassifications	-	-	-	-	-	**-**
Reclassified as held for sale and reversals	-	-	-	-	-	**-**
Disposals other than by sale	-	-	-	-	-	**-**
Upward revaluation gains	-	-	-	-	-	**-**
Impairments charged	-	-	-	-	-	**-**
Reversal of impairments	-	-	-	-	-	**-**
Charged during the year	4	-	-	-	-	**4**
Transfer (to) from other public sector body	-	-	-	-	-	**-**
Cumulative amortisation adjustment following revaluation	-	-	-	-	-	**-**
Amortisation At 31 March 2019	**15**	**-**	**-**	**-**	**-**	**15**
Net Book Value at 31 March 2019	**5**	**-**	**-**	**-**	**-**	**5**
Purchased	5	-	-	-	-	**5**
Donated	-	-	-	-	-	**-**
Government Granted	-	-	-	-	-	**-**
Total at 31 March 2019	**5**	**-**	**-**	**-**	**-**	**5**

Revaluation Reserve Balance for intangible assets

The Clinical Commissioning Group did not have any Revaluation Reserve Balances as at 31 March 2019.

14 Intangible non-current assets cont'd

14.1 Donated assets

The Clinical Commissioning Group did not hold any intangible non-current donated assets at 31 March 2019.

14.2 Government granted assets

The Clinical Commissioning Group did not hold any intangible non-current government granted assets at 31 March 2019.

14.3 Revaluation

The Clinical Commissioning Group did not have a revaluation at 31 March 2019.

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 2019.

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 2019.

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 2019.

14.7 Temporarily idle assets

The Clinical Commissioning Group did not have any temporarily idle assets as at 31 March 2019.

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 2019.

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 2019.

16 Inventories

	Drugs	Consumables	Energy	Work in Progress	Loan Equipment	Other	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Balance at 01 April 2018	-	-	2	-	-	-	**2**
Additions	-	-	-	-	-	-	**-**
Inventories recognised as an expense in the period	-	-	-	-	-	-	**-**
Write-down of inventories (including losses)	-	-	-	-	-	-	**-**
Reversal of write-down previously taken to the statement of comprehensive net expenditure	-	-	-	-	-	-	**-**
Transfer (to) from -Goods for resale	-	-	-	-	-	-	**-**
Balance at 31 March 2019	**-**	**-**	**2**	**-**	**-**	**-**	**2**

17.1 Trade and other receivables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
NHS receivables: Revenue	155	-	3,178	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	2,239	-	2,188	-
NHS accrued income	446	-	0	-
NHS Contract Receivable not yet invoiced/non-invoice	-	-	-	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	433	-	1,227	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,018	-	769	-
Non-NHS and Other WGA accrued income	66	-	135	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	-	-	-	-
VAT	126	-	128	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	1	-	0	-
Total Trade & other receivables	**4,484**	**-**	**7,625**	**-**
Total current and non current	**4,484**		**7,625**	
Included above:				
Prepaid pensions contributions	-		-	

17.2 Receivables past their due date but not impaired

	2018-19 DHSC Group Bodies £'000	2018-19 Non DHSC Group Bodies £'000	2017-18 DHSC Group Bodies £'000	2017-18 Non DHSC Group Bodies £'000
By up to three months	57	272	925	429
By three to six months	-	36	47	663
By more than six months	-	15	-	107
Total	**57**	**323**	**972**	**1,199**

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

There has been no impact from the application of IFRS 9 on financial assets at 1 April 2018.

17.4 Movement in loss allowances due to application of IFRS 9

There has been no movement in loss allowances due to the application of IFRS 9.

18 Other financial assets

The Clinical Commissioning Group did not have any other financial assets as at 31 March 2019.

19 Other current assets

The Clinical Commissioning Group did not have any other current assets as at 31 March 2019.

20 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	71	49
Net change in year	(23)	22
Balance at 31 March 2019	**48**	**71**
Made up of:		
Cash with the Government Banking Service	48	71
Cash with Commercial banks	-	-
Cash in hand	0	0
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**48**	**71**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 31 March 2019	**48**	**71**
Patients' money held by the clinical commissioning group, not included above	-	-

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 2019.

22 Analysis of impairments and reversals
The Clinical Commissioning Group did not make any impairments in 2018-19

23 Trade and other payables	Current 2018-19 £'000	Non-current 2018-19 £'000	Current 2017-18 £'000	Non-current 2017-18 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	2,816	-	2,945	-
NHS payables: Capital	-	-	-	-
NHS accruals	2,710	-	6,274	-
NHS deferred income	-	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	9,379	-	4,489	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	27,015	-	30,600	-
Non-NHS and Other WGA deferred income	16	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	119	-	113	-
VAT	-	-	-	-
Tax	102	-	95	-
Payments received on account	-	-	-	-
Other payables and accruals	643	-	787	-
Total Trade & Other Payables	**42,800**	**-**	**45,303**	**-**
Total current and non-current	**42,800**		**45,303**	

Other payables include £153,875 outstanding pension contributions at 31 March 2019.

The large element of the Non-NHS accruals above relates to GP prescribing and is based on the information currently held by Somerset Clinical Commissioning Group, if the accrual assessment was under assessed by 10% the impact would be £1,372k

23.1 Impact of Application of IFRS 9 on financial liabilities at 1 April 2018
There has been no impact from the application of IFRS 9 on financial liabilities at 1 April 2018

24 Other financial liabilities
The Clinical Commissioning Group did not have any other financial liabilities as at 31 March 2019.

25 Other liabilities
The Clinical Commissioning Group did not have any other liabilities as at 31 March 2019.

26 Borrowings
The Clinical Commissioning Group did not have any borrowings as at 31 March 2019.

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 2019.

28 Finance lease obligations
The Clinical Commissioning Group did not have any finance lease obligations as at 31 March 2019.

29 Finance lease receivables
The Clinical Commissioning Group did not have any finance lease receivables as at 31 March 2019.

29.1 Finance leases as lessor
The Clinical Commissioning Group did not have any unguaranteed residual value accruing as at 31 March 2019.

The Clinical Commissioning Group did not have any accumulated allowance for uncollectible lease receivables as at 31 March 2019.

29.2 Rental revenue
The Clinical Commissioning Group did not have any rental revenue as at 31 March 2019.

30 Provisions

	Current 2018-19 £'000	**Non-current 2018-19 £'000**	Current 2017-18 £'000	Non-current 2017-18 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	29	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	1,019	-	-	-
Continuing care	507	-	722	-
Other	-	-	-	-
Total	**1,555**	**-**	**722**	**-**
Total current and non-current	**1,555**		**722**	

	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 2018	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**722**	**-**	**722**
Arising during the year	-	-	-	29	-	-	1,019	507	-	**1,555**
Utilised during the year	-	-	-	-	-	-	-	(708)	-	**(708)**
Reversed unused	-	-	-	-	-	-	-	(14)	-	**(14)**
Unwinding of discount	-	-	-	-	-	-	-	-	-	**-**
Change in discount rate	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2019	**-**	**-**	**-**	**29**	**-**	**-**	**1,019**	**507**	**-**	**1,555**
Expected timing of cash flows:										
Within one year	-	-	-	29	-	-	1,019	507	-	**1,555**
Between one and five years	-	-	-	-	-	-	-	-	-	**-**
After five years	-	-	-	-	-	-	-	-	-	**-**
Balance at 31 March 2019	**-**	**-**	**-**	**29**	**-**	**-**	**1,019**	**507**	**-**	**1,555**

The above is based on the information currently held by Somerset Clinical Commissioning Group, if the provision assessment was under assessed by 10% the impact would be £156k

Following a staffing restructure within the Clinical Commissioning Group there remains a potential redundancy case outstanding as at 31 March 2019. A provision has therefore been made for the probability adjusted value of this redundancy case. A contingent liability in respect of this provision is shown in note 31.

The Clinical Commissioning Group has been notified of a Public Liability legal claim being processed by the NHS Litigation Authority and the notified value of this case has been included as a provision. Provision for a second legal claim is included relating to a contractual dispute. This provision allows for a potential claim spanning the life of the contract. A probability factor of 50% has been applied to reflect the likely outcome of an arbitration decision. A contingent liability in respect of these legal claim provisions is included in note 31.

The "Continuing Care" provision is an assessment of the continuing care cases which are currently being reviewed by the Clinical Commissioning Group's assessment 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. The probability factor applied is based on success rates in the current financial year. A contingent liability in respect of this provision is shown in note 31.
Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the Clinical Commissioning Group. However, the legal liability remains with the Clinical Commissioning Group. The total value of Previously Unassessed Periods of Care NHS Continuing Healthcare contingent liability accounted for by NHS England on behalf of this Clinical Commissioning Group at 31 March 2019 is £143k

31 Contingencies

	2018-19 £'000	2017-18 £'000
Contingent liabilities		
Equal Pay	-	-
NHS Resolution Legal Claims	-	-
Employment Tribunal	-	-
NHS Resolution employee liability claim	-	-
Redundancy	2	-
Continuing Healthcare	85	189
Litigation	103	-
Her Majesty's Revenue and Customs	-	-
Amounts recoverable against contingent liabilities	-	-
Net value of contingent liabilities	**190**	**189**
Contingent assets		
Amounts payable against contingent assets	-	-
Net value of contingent assets	**-**	**-**

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 2019.

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 2019.

33 Financial instruments

33.1 Financial risk management

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

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

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

33.1.1 Currency risk

The NHS 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 NHS Clinical Commissioning Group has no overseas operations. The NHS Clinical Commissioning Group and therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

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

33.1.3 Credit risk

Because the majority of the NHS Clinical Commissioning Group and revenue comes parliamentary funding, NHS 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.

33.1.4 Liquidity risk

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

33.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

33 Financial instruments cont'd

33.2 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	308		308
Trade and other receivables with other DHSC group bodies	359		359
Trade and other receivables with external bodies	434		434
Other financial assets	1		1
Cash and cash equivalents	48		48
Total at 31 March 2019	**1,150**	**-**	**1,150**

33.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Other 2018-19 £'000	Total 2018-19 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	563		**563**
Trade and other payables with other DHSC group bodies	16,757		**16,757**
Trade and other payables with external bodies	24,599		**24,599**
Other financial liabilities	643		**643**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2019	**42,562**	**-**	**42,562**

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	765,034	(3,247)	**761,787**	4,819	(44,355)	**(39,536)**
Total	**765,034**	**(3,247)**	**761,787**	**4,819**	**(44,355)**	**(39,536)**

34.1 Reconciliation between Operating Segments and SoCNE

	2018-19 £'000
Total net expenditure reported for operating segments	761,787
Total net expenditure per the Statement of Comprehensive Net Expenditure	**761,787**

34.2 Reconciliation between Operating Segments and SoFP

	2018-19 £'000
Total assets reported for operating segments	4,819
Total assets per Statement of Financial Position	**4,820**

	2018-19 £'000
Total liabilities reported for operating segments	(44,355)
Total liabilities per Statement of Financial Position	**(44,355)**

35 Joint arrangements - interests in joint operations

Integrated Community Equipment Service Pooled Fund

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

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

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

	2018-19 £'000	2017-18 £'000
Income		
Expenditure	1,260	1,169

Carers Services Pooled Fund

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

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

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

	2018-19 £'000	2017-18 £'000
Income		
Expenditure	225	245

Learning Disability Service Pooled Fund

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

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

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

	2018-19 £'000	2017-18 £'000
Income		
Expenditure	23,254	21,546

Better Care Fund

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

As a commissioner of healthcare services, the Clinical Commissioning Group makes contributions to the pools, which are then used to purchase health and social care services. The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure of the pool as determined by the pooled budget agreement.

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

	2018-19 £'000	2017-18 £'000
Income		
Expenditure	36,320*	35,639*

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

35.1 Interests in joint operations

Name of arrangement	Parties to the arrangement	Description of principal activities	Amounts recognised in Entities books ONLY 2018-19				Amounts recognised in Entities books ONLY 2017-18			
			Assets	Liabilities	Income	Expenditure	Assets	Liabilities	Income	Expenditure
			£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Integrated Comminity Equipment Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase healthcare equipment services	-	-	-	1,260	-	-	-	1,169
Carers Services Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Carers services	-	-	-	225	-	-	-	245
Learning Disability Service Pooled Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase Learning Disability services	-	-	-	23,254	-	-	-	21,546
Better Care Fund	NHS Somerset Clinical Commissioning Group and Somerset County Council	Purchase health and social care services	-	-	-	36,320	-	-	-	35,639

35.2 Interests in entities not accounted for under IFRS 10 or IFRS 11

The Clinical Commissioning Group did not have any interests in entities not accounted for under IFRS 10 or IFRS 11 as at 31st March 2019.

36 NHS Lift investments

The Clinical Commissioning Group did not have any NHS LIFT investments as at 31 March 2019.

37 Related party transactions

Details of related party transactions with individuals are as follows:

Appendix 1

31 March 2019	Payments to Related Party £ '000	Receipts from Related Partv £ '000	Amounts owed to Related Partv £ '000	Amounts due from Related Partv £ '000
Non-Executive Director and Chair of the Joint Committee for Commissioning Primary Care David Bell **(term ended 28/05/19)** is Principal at LGPS Resources - Planning and Highway Consultancy, a Planning Agent for Yeovil Town Football Club and Yeovil Town Holdings Limited Planning Applications, but no expenditure was incurred in year with any of these organisation	0	0	0	0
Non-Executive Director and Registered Nurse Dr Jayne Chidgey-Clark is a director of JCC Partnership Limited and is specialist advisor to the Care Quality Commission. Her spouse is a director and company secretary of JCC Partnership Limited and was Managing Director of Thera South West **(withdrawn 26/07/18)** before becoming interim manager at Hereford CCG **(added 26/07/18) (no expenditure was incurred with any of these organisation in year),** then Interim Head of Quality for NHS England Specialist Commissioning (South West) **(from 07/10/18)** (expenditure incurred with this organisation in year). Her daughter is an employee of PricewaterhouseCoopers **(withdrawn 11/10/18)**(no expenditure incurred with this organisation in year). Jayne Chidgey-Clark is the CCG nominated Governor of Somerset Partnership NHS Foundation Trust (expenditure incurred with this organisation in year)	136,786	188	94	257
Vice Chair and Non Executive Director Lou Evans is a director at Martin Brooks Associates Limited, is a member of the Avon and Somerset main committee for selection of a Justice of the Peace **(withdrawn 20/09/18) and is National Advisor to GPiC Ltd** (no expenditure was incurred with these organisation in year) and is the Clinical Commissioning Group's nominated governor for Yeovil District Hospital NHS Foundation Trust (expenditure incurred with this organisation in year).	87,911	0	614	673
Chair Dr Ed Ford is a West Somerset GP Commissioning Locality Chair, a first responder for Somerset Accident Voluntary Emergency Service (no expenditure incurred with these organisations in year), GP Partner at Irnham Lodge Surgery (expenditure incurred with this organisation in year), which is a training practice and member of West Somerset GP Commissioning Locality and a member of Somerset Primary Care Limited (expenditure incurred with this organisation in year). Dr Ford is a CCG member and Vice-chair of the Health and Wellbeing Board**.** His spouse is the Community Development and Liaison Practitioner for Musgrove Park Hospital (expenditure incurred with this organisation in year) and the Lead Nurse for the Living Better Project in West Somerset (**added 20/09/18**), and became Associate Director Primary Care Nursing and Allied Health Care Professionals at Musgrove Park Hospital (**w/ef 01/03/19**)	250,441	1,178	7,587	1,879
Non-Executive Director and Secondary Care Doctor Basil Fozard is a Bank Locum Consultant at The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust **(added 26/07/18)** (expenditure incurred with this organisation in year). His daughter is a GP in North London **(added 26/07/18)**, his daughter is a specialist registrar for Child and Adolescent Mental Health Services (CAMHS) at Tavistock & Portman NHS Foundation Trust **(added 26/07/18)** (no expenditure was incurred with this organisation in year) **and** University College London Hospitals NHS Foundation Trust **(added 26/07/18)** (expenditure incurred with this organisation in year), and his son is a Clinical Research Fellow in ENT at University College London Hospitals NHS Foundation Trust **(added 20/09/18, removed 01/10/18)** (expenditure incurred with this organisation in year). His spouse is a mental health act panel member at Dorset Healthcare NHS Foundation Trust **(added 26/07/18)** (expenditure incurred with this organisation in year)	2,634	0	98	0
Interim Chief Officer and CEC Chair **(from 01/02/19)**, previously Chief Operating Officer David Freeman's **(appointed 01/08/18)** step-daughter is a junior reporter with the Somerset County Gazette, part of Newsquest Media Group Ltd **(added 20/09/18)**(expenditure incurred with this organisation in year)	1	0	0	0
Programme Director: Fit For My Future Maria Heard (from 01/03/19) has no interests to declare.				
Interim Chief Operating Officer **(from 04/03/19)** Adrian Boyce is a director of Ascendor Solutions Ltd (no expenditure incurred in year), his brother is Adult Service User Governor at Northamptonshire Healthcare NHS Foundation Trust (expenditure incurred with this organisation in year), and his niece is directorate manager for Generalist & Specialist Surgery at Northampton General Hospital NHS Trust (expenditure incurred with this organisation in year).	42	0	1	0
Director of Public Health Trudi Grant is Director of Public Health at Somerset County Council (expenditure incurred with this organisation in year), a member of Somerset County Council's Health and Wellbeing Board, an Observer of the Board of Somerset Activity and Sports Partnership (no expenditure incurred with this organisation in year).	43,754	1,013	7,098	332
Non Executive Director, Patient & Public Engagement David Heath is Chair of Western Region and National Board Member of the Consumer Council for Water, Senior Independent Director for the Solicitors Regulation Authority, Non-executive director of Bath and Wells Multi-academy trust, and Chair of Policy and Public Affairs Board for the Institute and Faculty of Actuaries **(from 06/08/18) (no expenditure incurred with any of these organisations in year)**	0	0	0	0
Chief Finance Officer and Director of Performance Alison Henly has no interests to declare.				

Governing Body GP and CEC Vice Chair Dr Alex Murray is Bridgwater Bay Health Commissioning Locality Delegate (no expenditure incurred with this organisation in year), GP Partner at East Quay Medical Centre Bridgwater **(withdrawn 01/01/19)** which is a shareholder in Somerset Primary Healthcare Ltd, and is director and shareholder of both East Quay Health Ltd **(withdrawn 01/01/19)** and East Quay Vision Ltd **(withdrawn**	1,457	164	179	0
Chief Officer Nick Robinson and CEC Chair (**retired 31/01/19**) is managing director of Nick Robinson Consulting Ltd (not currently trading) which provides consultancy (no expenditure incurred with this organisation in year), financial and interim management support to NHS organisations. His spouse is employed as a Specialist Community Dietician by Essex Partnership University NHS Foundation Trust (expenditure incurred with this organisation in year).	2	0	0	0
Director of Strategic Clinical Services Transformation Dr Rosie Benneyworth (**resigned 01/03/19**) is a Board Trustee at Nuffield Trust and Vice Chair/Non-Executive Director (Acting Chair from September 18) at National Institute for Health and Care Excellence (NICE), and was salaried GP at Castle Place Practice, Tiverton (**added 01/02/19**) (no expenditure incurred with these organisations in year)	0	0	0	0
Director of Quality and Patient Safety Sandra Corry has a 5% share in her spouse's consultancy company QSI Limited which provides support to Health and Social Care sectors (no expenditure incurred with this organisation in year). Her spouse was employed by Somerset CCG as LeDeR Reviewer for the South West Region, funded by NHS England **(with effect from 11/06/18)** (expenditure incurred with this organisation in year)	0	183	6	157
Healthwatch Representative Judith Goodchild is a member of the Health and Wellbeing Board and Public Governor of Taunton & Somerset NHS Foundation Trust representing West Somerset (expenditure incurred with these organisations in year).	248,950	1,013	7,408	1,879
PPG Lay Observer Sandra Wilson is Chair of Exmoor Medical Centre PPG (expenditure incurred with this organisation in year), chair of Somerset PPG Chairs Network, Healthwatch Somerset Board Member (**added 24/09/18**), and Director of YLEM Ltd which supplies computer & IT Equipment and services (no expenditure incurred with these organisations in year).	1,144	0	0	0

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:

Appendix 2

31 March 2019	Payments to Related Party £ '000	Receipts from Related Party £ '000	Amounts owed to Related Party £ '000	Amounts due from Related Party £ '000
NHS England	0	183	6	157
South, Central and West Commissioning Support	4,562	0	503	0
NHS Herefordshire Clinical Commissioning Group	0	0	0	0
NHS FOUNDATION TRUSTS				
Dorset County Hospital NHS Foundation Trust	2,250	0	27	0
Dorset Healthcare NHS Foundation Trust	148	0	2	0
Essex Partnership University NHS Foundation Trust	2	0	0	0
Northamptonshire Healthcare NHS Foundation Trust	11	0	1	0
Royal Devon and Exeter NHS Foundation Trust	4,515	0	10	3
Royal United Hospital Bath NHS Foundation Trust	32,824	0	899	189
Salisbury NHS Foundation Trust	730	0	61	0
Somerset Partnership NHS Foundation Trust	136,786	5	88	100
South Western Ambulance Service NHS Foundation Trust	21,999	0	26	0
Taunton & Somerset NHS Foundation Trust	205,196	0	310	1,547
Tavistock & Portman NHS Foundation Trust	0	0	0	0
The Royal Bournemouth & Christchurch Hospitals NHS Foundation Trust	104	0	13	0
University College London Hospitals NHS Foundation Trust	279	0	58	0
University Hospitals Bristol NHS Foundation Trust	8,960	0	358	7
Yeovil District Hospital NHS Foundation Trust	87,911	0	614	673
NHS TRUSTS				
North Bristol NHS Trust	7,409	0	251	0
Northampton General Hospital NHS Trust	31	0	0	0
Northern Devon Healthcare NHS Trust	508	0	50	0
Weston Area Health NHS Trust	14,967	0	526	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

Delegation of Primary Care Medical Services from NHS England - The NHS Somerset CCG will take over commissioning responsibility for Primary Care Medical Services from NHS England from 1st April 2019. The approximate value of the funding transfer is £75.883m. This is a non-adjusting event in respect of the 2018/19 Annual Accounts of the CCG.

39 Third party assets

The Clinical Commissioning Group held no third party assets as at 31 March 2019.

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:

	2018-19 Target £'000	**2018-19 Performance £'000**	2017/18 Target £'000	2017/18 Performance £'000
Expenditure not to exceed income	765,033	765,033	743,426	743,966
Capital resource use does not exceed the amount specified in Directions	50	50	35	35
Revenue resource use does not exceed the amount specified in Directions	761,787	761,787	736,572	737,112
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	50	50	35	35
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	749,837	751,062	724,690	726,120
Revenue administration resource use does not exceed the amount specified in Directions	11,950	10,725	11,882	10,992

The NHS Somerset CCG financial targets and performance were all met in 2018-19.

NHS Somerset CCG planned to deliver a deficit of £9,000,000 for 2018/19 against the portfolio of the services we commission, as agreed with NHS England. The CCG was eligible to receive £9,000,000 Commissioner Sustainability Funding (CSF) in year, subject to a review by NHS England against achievement of the financial plan and adherence to the conditions of the CSF. We have demonstrated achievement of the CSF conditions for 2018/19 and have therefore been confirmed as eligible to receive the full funding available, therefore enabling the CCG to deliver a balanced position for 2018/19.

41 Analysis of charitable reserves

	2018-19 £'000	2017/18 £'000
Unrestricted funds	-	-
Restricted funds	-	-
Endowment funds	-	-
Total	**-**	**-**

42 Effect of application of IFRS 15 on current year closing balances

Somerset Clinical Commissioning Group considers that it does not have any revenue sources to which application of IFRS15 would have any material impact to the way that it has historically been reported.

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

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of NHS Somerset Clinical Commissioning Group (the 'CCG') for the year ended 31 March 2019, which comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018/19.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the CCG as at 31 March 2019 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19; and
- have been prepared in accordance with the requirements of the Health and Social Care Act 2012.

Basis for opinion

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

Conclusions relating to going concern

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the

other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19 and the requirements of the Health and Social Care Act 2012; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the CCG gained through our work in relation to the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Opinion on regularity required by the Code of Audit Practice

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

Matters on which we are required to report by exception

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

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

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

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

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

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and

using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in November 2017, except for the effects of the matter described in the 'Basis for qualified conclusion section' of our report, we are satisfied that in all significant respects NHS Somerset Clinical Commissioning Group put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

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

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

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

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

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(1)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Geraldine N Daly

Geraldine N Daly, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

2 Glass Wharf

Temple Quay

Bristol BS1 0EL

Date 28 May 2019