Annual Review

NHS
Gloucestershire
Clinical Commissioning Group

Social Prescribing

improving well-being and connecting communities

Helping people achieve a healthy weight

Joining up your Information

Eye Health Update

What's inside!
county and locality news special...

ADVICEASAP

2015
2016

Annual Report 2015/16

A message from:

This is the third Annual Report for NHS Gloucestershire Clinical Commissioning Group and it's good to highlight the progress made.

As you will see, great work is going on across the county and within our local communities to improve health and care despite the challenges facing the NHS.

We are placing greater emphasis on prevention and self-care and joining up services and support across health and social care.

We are also developing alternatives to hospital care, including more care, treatment and support at home, in your GP surgery and in your local community.

This Report highlights some of the things the Governing Body, localities and member practices are doing with a range of community partners, but we acknowledge that this is just the beginning of the journey. Much more needs to be done if we are to put the NHS on a sound financial footing for the future and meet the health needs of you and your family in the years to come.

Looking ahead, we believe that by all working together in Gloucestershire in a joined up way we can build stronger, healthier communities and transform the quality of care and support we provide to all local people.

It is clear however, that if we are going to realise this ambition and meet the challenges of a growing population with more complex needs, we are going to have accelerate the pace of change and be even more ambitious and innovative in how we organise services and use the resources available to us.

We are fortunate in Gloucestershire to have excellent community partnerships in place – at county and locality level. We will need to harness all of this goodwill – the knowledge, skills, energy and commitment – to ensure that people across our county have access to good quality information, strong networks of support and access to safe and effective care when needed.

As we develop our plans, we will continue to use the feedback we receive from patients, carers, clinicians and members of the public to guide our decision making.

We wish you the best of health.

Dr Helen Miller
Clinical Chair

Dr Andy Seymour
Clinical Chair
(from May 2016)

Mary Hutton
Accountable Officer

Prevention, early diagnosis and improving well-being

Social Prescribing

improving well-being and connecting communities

All of Gloucestershire's seven localities are now running social prescribing pilot schemes to support people who go to their GP surgery, but who do not necessarily require medical care.

As a result of close partnership working between the CCG, local councils, Gloucestershire Care Services NHS Trust and a range of voluntary and community organisations, around 1,700 people have been supported this year to connect to services and groups that can help improve their well-being and meet their wider needs.

Social prescribing supports people with issues such as loneliness, low level mental health, healthy living and coping with caring responsibilities.

Although every locality has a scheme, some localities have established social prescribing hubs, while others are using local area co-ordinators.

Evaluation of the pilot schemes will inform future development of the service.

Cultural commissioning

grant programmes now underway

The CCG was this year selected to become one of only two areas in England to explore opportunities for incorporating arts and culture into the services it buys for people living in Gloucestershire to help improve their health and wellbeing.

This is a programme funded by the Arts Council to link health services with arts organisations, museums, libraries and music.

Over the past six months, the CCG, working with a range of partners, has invited local arts and culture organisations to explore how arts and culture may help reduce ill health and support people with long term conditions.

Clinicians, patients and artists have been working together to develop services that use arts and culture to support people with dementia, lung conditions, diabetes, chronic pain and mental health through, for example, music therapy, art, drama, comedy, animation, singing and song writing.

They are also exploring how arts can support weight loss programmes and help people diagnosed with colorectal and prostate cancer to feel more confident and lead healthier lives.

Helping people achieve a healthy weight

A countywide scheme to help obese adults to achieve and sustain a healthy weight is continuing to benefit thousands of people this year.

The CCG has supported the Weight Management on Referral Scheme, funded by the County Council, which is helping to tackle obesity and prevent ill health.

GPs and other health professionals have been able to refer people to groups, run by Slimming World and available in every district.

This year, the scheme has delivered a total weight loss across Gloucestershire of 20,777kgs and has helped over 4,400 people. Partners are now working together to consider how best to support people in the future.

In Gloucestershire, nearly 23.5% of adults are obese. Obesity can have a significant impact on the health of both adults and children.

A big step in the fight against obesity

CCG and partners set out plans

Looking ahead, the CCG, together with Gloucestershire County Council, is stepping up the fight to help people in the county lose weight and stay healthy.

In December, the county held a Healthy Weight workshop with more than 60 stakeholders from across the public and voluntary sectors.

A number of objectives were agreed and we are excited about taking initiatives forward with our partners.

This includes working with schools to encourage healthy eating and encouraging planners and licensing authorities to consider footpaths, cycle paths and playing fields in their plans.

Other plans include inspiring more people to keep active, for example, through the 'Walk a Mile' scheme in schools that encourages children to walk, run or skip a mile each day.

Eye Health

Children's visual screening success

Avoidable sight loss is being reduced and life choices for children in Gloucestershire are being enhanced thanks to changes in Children's visual screening.

The improved arrangements, for 4 and 5 year old school children, include the screening test for refractive errors and amblyopia ('lazy eye').

The new electronic system uses a lap top and headphones with instructions available in different languages. The more efficient 3 minute test is easier to audit and allows additional time to measure height and weight.

The results are impressive – an audit shows that screening uptake has increased from 66% to 90% (change in parental consent to opt out rather than to opt in), false positives have reduced from 31% to 18% and true positives have increased from 5% to 12%.

The developments in eye health are a result of joint working between the CCG, NHS Trusts, school nurses, the County Council and Community Optometrists.

Gloucestershire's NHS secures funding to promote good mental health in schools

14 schools in Gloucestershire are now benefitting from £85,000 worth of funding and are joining together with local health services to improve children's mental health.

The CCG worked with partners, including Gloucestershire County Council and [2]gether NHS Foundation Trust, to submit the county's case to government in a bid to secure the money.

It means schools are getting better support around children's mental health and easier access to local, specialist mental health services where appropriate.

The CCG has invested an additional £50,000 in the project which will be piloted initially in the Stroud and Berkeley Vale area. The results will inform new ways of working across the whole county.

Improving early diagnosis for dementia – rate rises to over 66% in the county

GPs and healthcare staff across Gloucestershire are making positive strides to improve dementia care and support. Over 66% of people are now diagnosed compared to 32% just six years ago.

This improvement, which is based on the estimated number of people with dementia in the county, has been made possible by good engagement between healthcare professionals and follow up on the signs and symptoms.

This means that more people with dementia and their carers are receiving early advice and support.

The CCG and its partners produced a film with ITN productions for the NHS Alliance, which highlights the innovative work going on in Gloucestershire to improve early diagnosis and community support.

It is estimated that there are nearly 9,000 people with dementia in Gloucestershire.

Helping people live with and beyond cancer

The CCG has teamed together with Macmillan in Gloucestershire to support people to improve their health and wellbeing during treatment and into their recovery.

In hospital, patients are now benefitting from the Cancer Recovery Package, which includes a full assessment of their needs, a personal care plan and a Treatment Summary to improve communication with their GP.

Patients also have better access to information and education, and with Macmillan's valuable support, a pilot community-based service (Next Steps) was launched in April 2016. Available initially in two areas of the county it helps people living with the after effects of cancer.

During the year, a series of specific cancer masterclasses have been run for GPs to increase awareness of the signs and symptoms and to support early diagnosis.

Making the most of digital technology

Digital technology set to improve care for diabetes patients

Patients in Gloucestershire will be among the first to benefit from a new initiative to modernise how the NHS delivers care.

The CCG is part of an innovative project, led by the West of England Academic Health Science Network, which will allow people with diabetes to try out self-management technologies, such as wearable sensors, to help them manage their condition.

It is called the 'Diabetes Digital Coach' test bed project, and the initiative will support people with Type 1 or Type 2 diabetes to self-manage their condition and seek the right kind of help when they need it.

The CCG played a key role in developing the regional bid with Accountable Officer, Mary Hutton being the programme's Executive Sponsor.

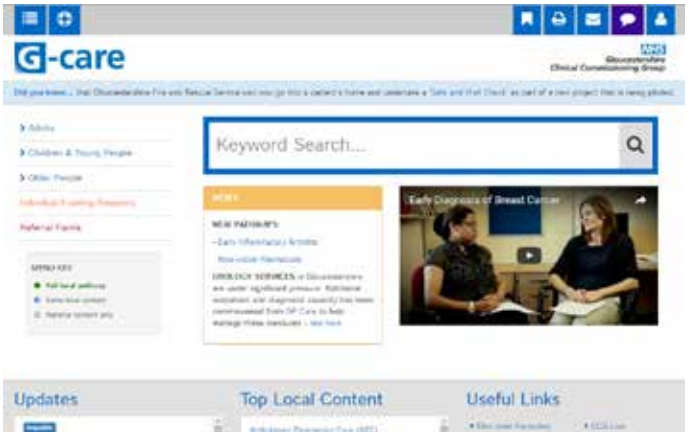
1,000 G-Care users

site making a real difference to health professionals and patients

'G-care' was launched by the CCG in July 2015 and is a new 'Clinical Information Website' for health professionals in Gloucestershire – it currently has over 1,000 users.

It helps GPs keep up to date with the latest prescribing guidance, new ways of treating a certain condition, as well as knowing where to find the latest information from other local health providers, such as contact details or new referral forms.

G-Care also gives GPs, and primary care teams, the latest information to either help patients to manage their own care or refer them to the right services and support at the right time.



The site has also helped improve the information patients are given as GPs are able to provide a range of health and wellbeing resources, including leaflets.

Users are accessing G-care around 3,000 times a month and it has received positive feedback from health professionals.

New ASAP Health App hits 7,500 downloads

The NHS in Gloucestershire launched it's ASAP campaign in April 2015 and it has already resulted in over 7,500 App downloads and over 12,000 website visits.

The initiative targets adults and parents of young children with advice on what to do if they are ill or injured and are unsure where to turn.

The promotional material encourages residents to check out the App (ASAP Glos NHS), Search the website (**www.asapglos.nhs.uk**), Ask NHS 111 or visit their Pharmacy.

The ASAP website and App allows users to 'Search by Service' or 'Search by Condition' – providing a step-by-step guide through symptoms, self-care and signposting to the appropriate NHS service/s.

The App and website has the backing of local councils, doctors, pharmacists and community groups.

ADVICEASAP

Joining Up Your Information
to improve patient safety and care

The NHS and County Council in Gloucestershire are improving the way health and social care professionals share important patient information by giving them carefully controlled access to a secure online system.

Currently, service users often have to repeat their stories each time they see a health or social care worker. This is because care providers have different sets of records on systems that are not always joined up.

With the consent of patients, the system will allow the most up-to-date care information about the individual to be shared securely, for example, details that different health and care teams already share through telephone calls, letters and faxes.

More information is available at: **www.mylocalsharedcareinfo.org**

Video GP consultations and e-consultations being trialled in the county

Some GP practices in the county have begun trialling video consultations this year with patients, where it's safe, appropriate and convenient to do so.

This small trial, using Skype, intends to test the concept and, if successful for patients and practices alike, it will be rolled out to other GP surgeries across the county.

Eighteen GP practices are also trialling E-consultation software, such as 'askmyGP', available from their practice website.

Patients can seek help through answering a series of questions about their symptoms – on their smartphone, tablet or computer – which allows a much quicker initial assessment by the GP practice.

A swift decision can then be made by the surgery on whether to see or call the patient, and which member of the primary care team is best placed to support them.

Support at home and in the community

Choice+
improving access to GP care

As part of the county's successful Prime Minister's Challenge Fund bid, around 33,000 additional urgent appointments have been made available at health facilities across Gloucestershire this year.

It has resulted in increased access to GP care between 8 am and 8 pm (Monday to Friday) and on Saturdays.

Patients who need an urgent appointment with a doctor can wait for the next available slot at their GP surgery or choose to attend another healthcare centre in the local area.

It also frees up time at the GP surgery for doctors to spend more time with patients with chronic long term health conditions.

Choice+ was first set up in Gloucester (see page 13) but schemes are now in place in every locality.

Care Homes service leads to fewer emergency hospital visits

The Gloucestershire GP Care Homes enhanced service is delivering real benefits to residents and staff since it got underway.

The result of the initiative is that people living in care homes in Gloucestershire are now receiving more planned and proactive support from GPs.

Doctors are carrying out regular planned visits (at least fortnightly), assessing medical needs, reviewing medicines and reviewing the reasons for hospital visits.

An evaluation of the scheme at the end of the first year showed a 25% reduction in emergency hospital attendances amongst care home residents. The scheme is continuing to have a positive impact in 2015/16.

Joined up care – supporting people at home and in the community

Investment in joined up Health and Social Care Community Teams (ICTs) is benefitting patients across the county with 24 hour a day, 7 day a week support where they live.

The development, through Gloucestershire Care Services NHS Trust, has helped around 16,200 patients this year, providing them with extra support at home, reducing unnecessary hospital stays and helping patients to return home sooner after operations or treatment.

Over 2,577 patients who need urgent care after a crisis or unexpected event at home have been treated by the Rapid Response Service (response within 1 hour) this year.

Also this year, a project to strengthen team working in ICTs and build closer relationships with mental health services and voluntary and community organisations for the benefit of patients was piloted in Stroud and Berkeley Vale (see locality section).

New community eye care service announced to provide care closer to home and reduce waiting times

A new organisation, Primary Eyecare Gloucestershire (PEG), has been awarded the contract to provide community eye health services for the county.

PEG was formed by Gloucestershire Local Optical Committee and manages a network of established and experienced optometrists.

The new service will help patients access the right services closer to home through community opticians, often reducing the need to wait for hospital appointments.

The service also hopes to raise awareness of conditions such as glaucoma and encourage people, particularly those who are at high risk, to get their eyesight tested.

Services will be introduced over the course of this year from May, starting with glaucoma. The second phase will introduce new cataract services, followed by specific minor eye conditions in autumn and children's services at the end of the year.

LDISS recognised as 'best practice' service
over 150 people receive support to date

The Learning Disability Intensive Support Service (LDISS) commissioned by the CCG and County Council has been highlighted as 'best practice' by NHS England.

The service, provided by 2gether NHS Foundation Trust, offers support for children, young people and adults to prevent the need for stays in hospital and facilities outside the county.

Available 365 days a year, LDISS can provide hands on support over a 24 hour period to clients and health professionals.

Since 1 April 2014, over 150 people have used the service, including those who were at risk of a hospital stay or having to move or leave their current place of residence.

Also this year, the CCG and County Council have transformed Coombe End in Gloucester, which used to be a residential home, into eight independent, purpose-built flats to support people with severe learning difficulties and behavioural challenges.

Supporting patients

in the self-management of their respiratory disease

Real progress is being made in providing people with COPD (Chronic Obstructive Pulmonary Disease) with a structured programme of exercise and education to support them in the management of their condition.

COPD is the name for a collection of lung diseases and people with COPD have difficulties breathing, mainly due to the narrowing of their airways.

Pulmonary Rehabilitation provides people with information about their condition and the management of their symptoms.

The PR programme, provided by Gloucestershire Care Services NHS Trust, along with other innovative approaches such as remote monitoring of people's condition/symptoms, is supporting people to keep well in their own homes.

The CCG has also commissioned a range of films (called 'Sound Doctor') to highlight real life stories and to provide advice on self-management of the condition.

Members of the Community Urology Team

New community urology service reduces waiting times

The CCG has recently commissioned a new community service for patients with common urological conditions such as kidney, bladder or urinary tract problems. It is provided by GP Care at the Aspen Centre in Gloucester.

The service means that patients can be assessed and have any diagnostic tests they need to identify the nature of the illness in a non-hospital setting, as part of a single appointment.

Waiting times are very short (around two weeks) which can help reduce patients' anxieties, and most patients leave the appointment with a clear diagnosis and care plan.

The CCG are working with GP Care to extend the service to another location in the county so that more patients can benefit.

High quality hospital care when needed

Older people's advice

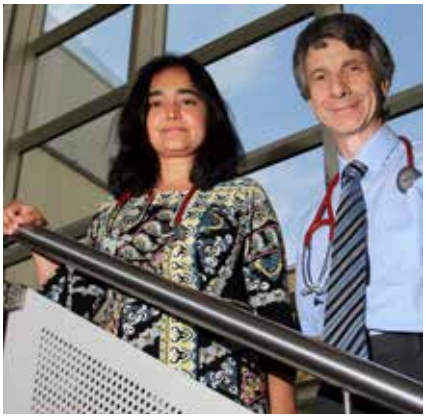
and liaison service – same day assessment, treatment and support

The Older People's Advice and Liaison Service (OPAL) provides intensive medical support to older patients in Gloucestershire's two large hospitals to improve quality of care and avoid hospital stays where appropriate.

The service is provided within the emergency department and on wards at Gloucestershire Royal and Cheltenham General Hospitals. Led by Consultant Geriatricians, it is supported by other hospital staff and Rapid Response teams in the community.

Over 2000 patients have used the service this year. Results so far have been excellent with around 60% of service users able to return home safely the same day following review and treatment.

Through close working between GPs, community teams, the ambulance service and hospital staff the aim is to reduce the number of patients who need to go back to hospital.



Same day AEC service for patients

Ambulatory Emergency Care units at Cheltenham General and Gloucestershire Royal Hospitals are continuing to reduce the need for patients to stay in hospital, take pressure off Emergency Departments and improve the quality of care.

The service means patients are assessed, diagnosed, treated and are able to go home the same day, with follow up care arranged if needed.

The units can see patients who have been reviewed by their GP and GPs are able to call a single telephone number to access the service.

Patients are referred to the service if doctors think there's a good chance that they will be fit to leave hospital within the opening hours of the unit.

New Irritable Bowel Syndrome (IBS) Service up and running

From January 2016, a new Refractory IBS Service got underway to support patients who may not respond to usual treatments for IBS and so their condition can be difficult to manage.

The service, provided by Gloucestershire Hospitals NHS Foundation Trust, prevents these patients from being extensively investigated unnecessarily with colonoscopy and other tests.

The service is run by specialist dietitians, with support from consultant gastroenterologists, and will provide approximately 300 refractory IBS sufferers per year with assessment, support with management of their condition and further investigation if needed.

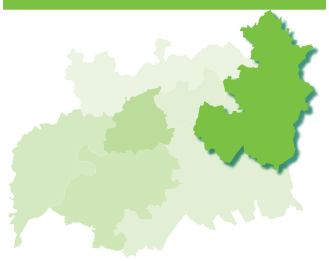
The diet recommended by the service can be highly successful in treating these patients and providing relief of symptoms.

Alex Di Mambro and Clare Oldale from the Refractory IBS Service

Locality News

North Cotswolds

North Cotswolds



Pop. approx. 28,996

5 practices

20 GPs

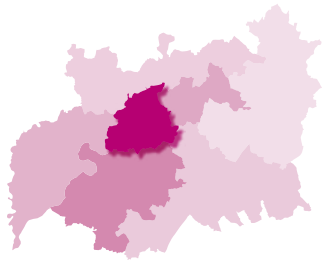
Covering Chipping Campden, Bourton-on-the-Water, Moreton-in-Marsh, Stow-on-the-Wold, Blockley, Northleach

- **Social Prescribing scheme successfully up and running** – all practices within the North Cotswolds are now involved in the initiative provided by Cotswold Friends. It gives GPs the ability to refer patients who do not necessarily have a medical need to sources of community support.
- **Greater support for Carers** – 'Carers Afternoons' have been held at each GP practice in the locality this year. Health checks were available and organisations were able to offer advice, guidance and support to those who provide care. The GP surgeries have also increased the length of carers health check appointments and designed questionnaires and consultation forms to help health professionals better understand the needs of carers.
- **Community support for people living with and beyond cancer** – the Macmillan Community Cancer Service (Next Steps) was launched on 4 April 2016 in the North Cotswolds and Gloucester on a pilot basis until December 2017. The service will provide 1:1 clinic time and self-management advice to patients that have received treatment for breast, colorectal or prostate cancer and have now left hospital.

Locality News

Gloucester

Gloucester



Pop. approx: 169,681

18 practices

119 GPs

Covering Abbeydale, Churchdown, Gloucester, Hardwicke, Highnam, Hucclecote, Longlevens, Matson, Quedgeley, Saintbridge

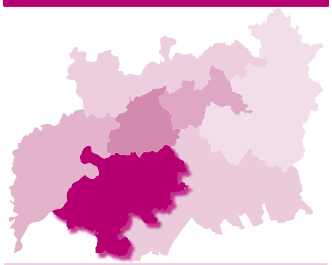
- **Choice+ offering more convenience for patients** – 300 extra same day appointments are now available each week at two city health centres for those who really need to see a doctor that day, but their own surgery doesn't have an available slot. The initiative, which also frees up time in GP surgeries for doctors to spend more appointment time with their patients who have chronic conditions, first got underway in the City and is now available in every locality across Gloucestershire.
- **Social Prescribing scheme goes from strength to strength** – three new hub co-ordinators and an admin worker have joined the team this year connecting people to community services and support. There have been just under 300 referrals from GPs in the area this year to date.
- **Gloucester City GPs promoting healthy lifestyles** – Family doctors have been learning techniques that will help them motivate patients to make healthy choices and signpost to local physical activity and sports activities.
- **Think Pharmacy First** – the locality has been promoting the Pharmacy Minor Aliments Scheme to GP practices, healthcare professionals and patients in Gloucester City. It's helping to reduce the need for GP appointments by providing medication for common ailments through local pharmacies and has been particularly successful for use by parents of younger patients. It's now being rolled out countywide.

Locality News

Stroud and Berkeley Vale

- **Social Prescribing pilot helps around 350 people this year** – The scheme, a partnership between the CCG, Stroud District Council and a range of community and voluntary organisations, connects people without a clear medical need to social and community support. The most common reasons for referral by a GP surgery this year were social isolation and mental health and wellbeing. The locality's innovative approach also includes Cycling and Arts on Prescription projects.
- **Facts4Life:changing attitudes to personal health and well-being** – This ground breaking project helps children in Key stage 1 to understand how to keep as well as possible and how to manage ill-health effectively. The approach allows children and teachers to start talking about difficult and important personal and family health issues. Health problems can be identified more quickly and interventions carried out an earlier stage, without the need for medical involvement.
- **Four memory cafés up and running in Stroud, Cam, Wotton and Berkeley** – sited within sheltered housing complexes, they are accessible to all patients (and Carers) from Stroud District who have concerns about their memory. The café sessions are run in partnership with a Dementia nurse and Dementia advisors.
- **Joined up community teams** – A project to strengthen team working between local health and social care professionals and build closer relationships with mental health services and voluntary and community organisations was piloted in Stroud and Berkeley Vale this year. The initiative also works to support people to retain their independence, avoid unnecessary stays in hospital and connect people in most need to resources in their local community. Plans are in place to share the learning countywide.

Stroud and Berkeley Vale



Pop. approx: 119,583

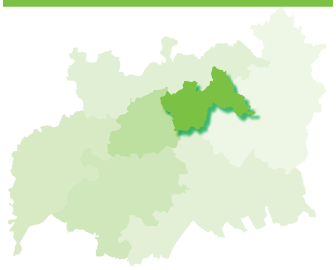
18 practices

94 GPs

Covering Berkeley, Minchinhampton, Nailsworth, Stonehouse, Stroud, Dursley, Cam, Frampton-on-Severn, Uley, Wotton-under-Edge, Bussage, Painswick

Locality News

Cheltenham



Pop. approx: 152,503

17 practices

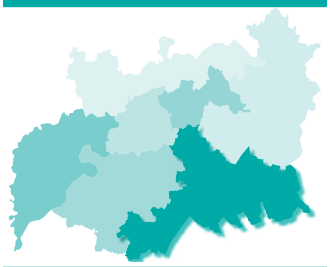
112 GPs

Covering Bishops Cleeve, Charlton Kings, Cheltenham, Hesters Way, Leckhampton, Prestbury, Springbank, Up Hatherley, Winchcombe

- **Prescribing project for Older People gets off the ground** – an in depth review of medicines for patients over 85 years, who are prescribed 10 or more drugs, is underway in the locality. These patients are at risk of side effects and falls which can lead to a stay in hospital. The pilot is being conducted by support pharmacists in four GP practices using evidence based guidelines.
- **Cheltenham GPs going the extra mile to support Carers** – GP practices in the area are exploring new ways to help carers. This includes contacting those who haven't had a recent health check and could benefit from support. Practices can put them in touch with the local Social Prescribing Co-ordinator who has extensive knowledge of community services and support groups.
- **Additional support to bring down Alcohol related A&E attendances** – a review of alcohol related attendances at A&E was carried out to understand if any additional support could be provided in GP surgeries. A number of GP surgeries were offered the opportunity to have in-house appointments for their patients from Turning Point, who provide specialist services and support.
- **The locality's Social Prescribing project has gathered momentum this year** – with 447 patients benefitting to date. The scheme, run in collaboration with Cheltenham Borough Council and Cheltenham Partnerships, connects local people who attend their GP surgery with no clear medical need with sources of community and social support. Referrals from GP surgeries have steadily increased and people have received support around social isolation, housing, financial advice and mental health and wellbeing.

Locality News

South Cotswolds



Pop. approx: 58,138

8 practices

43 GPs

Covering Cirencester, Fairford, Lechlade, Rendcomb, Tetbury, South Cerney, Kemble

South Cotswolds

- **Local GPs and community partners have set their sights on support closer to home** – and this includes cardiology diagnostic tests. They have developed a scheme that will enable these heart rate and rhythm tests (ECGs) to be undertaken locally, rather than in hospital, while providing a safe and cost effective service for patients and the NHS. Work to pilot the scheme across the locality has already begun.
- **The South Cotswolds Social Prescribing scheme is making a real difference** – thanks to strong partnership working with Cotswold District Council and a range of voluntary and community organisations. GPs refer patients to a 'hub' where the co-ordinator is able to signpost people to sources of support and advice. Over 230 patients have benefitted so far, with the majority of referrals related to social isolation and caring responsibilities.
- **A new service to provide care for people with serious leg ulcers** – is up and running in the South Cotswolds. The service aims to deliver the best available treatment and management of leg ulcers, combined with social support, in a friendly environment close to home.
- **Early action on Dementia** – Learning events for South Cotswolds GPs have been held this year to increase awareness and to support dementia diagnosis. This has led to an increase in the recording of dementia cases in the local area and formal memory testing. The initiative has ensured that more people and their carers have been able to access appropriate support earlier.

Locality News

Tewkesbury
Newent and Staunton

- **Second Social Prescribing pilot in place** – following successful launch of the scheme in Tewkesbury in April 2015, a second one got underway in Newent and Staunton in September. The schemes run in partnership with the District Councils, signpost people with non-medical needs to support from local organisations and groups. Social prescribing can help people to live healthier lives, support people with caring responsibilities, mental health and wellbeing issues and reduce social isolation.
- **Health Centre will provide a high quality care environment for patients** – building work is now underway on the new GP facility next to Tewkesbury Hospital. Mythe Medical Practice and Church Street surgery will both be located in the facility and the Centre will offer a range of other services for local patients such as pharmacy, counselling services, phlebotomy and additional consultant rooms.
- **Joined up care for children** – GPs in Tewkesbury have set up new ways of working to improve links with other healthcare professionals who care for ill children. GPs now meet each month with paediatricians, therapists, community and school nurses and other professionals to review how and where children receive care. This ensures children get the best possible support and it's an opportunity for professionals to learn from one another.
- **The Pharmacy First Minor Ailment scheme launched in the local area this year** – the initiative means that patients can get advice, medicines and other appropriate treatment from experienced pharmacists for a range of common illnesses. Patients often get the medicines they need straight away, either free of charge, or at a lower cost than standard prescriptions. If the pharmacist decides that someone needs to see a doctor, they will be referred back to their GP surgery. The successful scheme is now being rolled out countywide.

Tewkesbury, Newent and Staunton

Pop. approx 42,878

5 practices

19 GPs

Covering Tewkesbury, Newent, Staunton, Corse

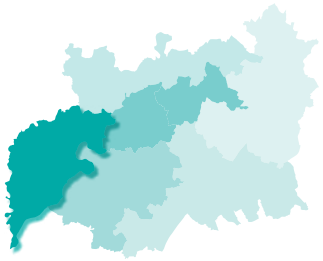
Joined Up Care for Children

Locality News

Forest of Dean

- **Workshop to promote healthy lifestyles** – Local GPs and the District Council joined forces this year to host the event which looked at ways of improving support to local residents. The action plan includes further development of the local social prescribing scheme (see below), introducing 'The Daily Mile' with local primary schools to promote physical activity, work with social care to support young people to become more active and work with local voluntary organisations to support residents in setting up community activities such as walking clubs and park runs.
- **Social Prescribing scheme goes from strength to strength** – the community initiative in the Forest of Dean was set up to support patients who go to their GP surgery, but do not necessarily have a clear medical need. The project team includes a range of local partners and the scheme has been further developed this year to include sessional time in GP surgeries so that the co-ordinators can provide 1:1 support to local people. At the time of writing, the scheme has helped over 270 patients in the district this year.
- **Greater advice and support to patients with lung disease** – a survey of local patients with chronic obstructive pulmonary disease (COPD), showed that many had a poor understanding of their lung disease. GP surgeries are now working together with the community respiratory service to offer groups of newly diagnosed COPD patients (and their carers) the opportunity to attend weekly education courses close to home. These sessions help them better understand their disease, make good use of their medicines, avoid making the condition worse and point them in the right direction for local services and help.

Forest of Dean



Pop. approx. 62,924

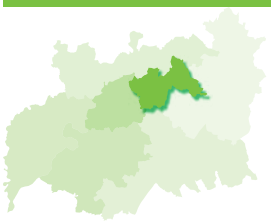
11 practices

44 GPs

Covering Blakeney, Coleford, Cinderford, Drybrook, Lydney, Mitcheldean, Newnham-on-Severn, Westbury-on-Severn, Yorkley, Bream, Ruardean, Lydbrook

Member Practices
by locality

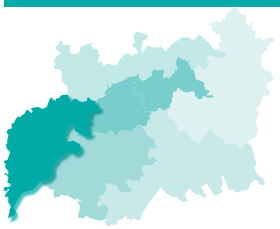
Cheltenham



Cheltenham Locality:

Berkeley Place Surgery
Crescent Bakery Surgery
Corinthian Surgery
Leckhampton Surgery
Overton Park Surgery
Portland Practice (The)
Royal Crescent Surgery
Royal Well Surgery
Sevenposts Surgery
Sixways Clinic
Springbank Community Resource Centre
St Catherine's Surgery
St George's Surgery
Stoke Road Surgery
Yorkleigh Surgery
Winchcombe Medical Practice
Underwood Surgery

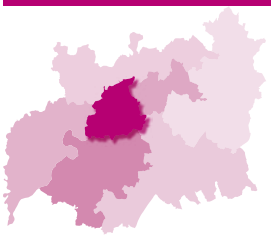
Forest of Dean



Forest of Dean Locality:

Blakeney Surgery
Brunston Practice
Coleford Health Centre
Dockham Road Surgery
Drybrook (The Surgery)
Forest Health Care
Lydney Practice
Mitcheldean Surgery
Newnham on Severn (The Surgery)
Severnbank Surgery
Yorkley Health Centre

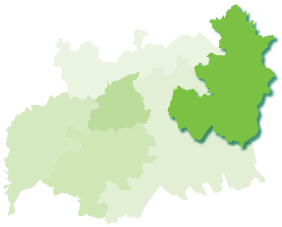
Gloucester City



Gloucester City Locality:

Barnwood Medical Practice
Bartongate Surgery
Brockworth Surgery
Cheltenham Road Surgery
Churchdown Surgery
Gloucester City Health Centre
Gloucester Health Access Centre
Hadwen Medical Practice
Heathville Medical Practice
Hucclecote (The Surgery)
Kingsholm Surgery
London Medical Practice
Longlevens Surgery
Matson Surgery
Partners in Health
Quedgeley Medical Centre
Rosebank Health
Saintbridge Surgery
The College Yard & Highnam Surgeries

North Cotswolds

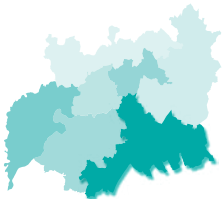


North Cotswolds Locality:

Chipping Campden Surgery
Cotswold Medical Practice
Mann Cottage Surgery
Stow Surgery
White House Surgery

Member Practices
by locality

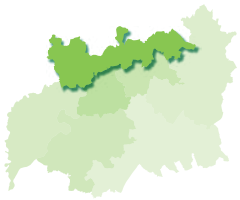
South Cotswolds



South Cotswolds Locality:

Avenue Surgery (The)
Hilary Cottage Surgery
Medical Centre, Lechlade (The)
Park Surgery (The)
Phoenix Surgery
Rendcombe Surgery
Romney House Surgery
St Peter's Road Surgery

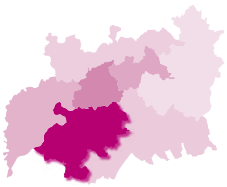
Tewkesbury, Newent and Staunton



Tewkesbury, Newent and Staunton Locality:

Church Street Practice (The)
Corse (The Surgery)
Mythe Medical Practice
Newent Doctors' Practice

Stroud and Berkeley Vale



Stroud and Berkeley Vale Locality:

Acorn Practice
Beeches Green Surgery
Cam & Uley Family Practice
Chipping Surgery (The)
Culverhay Surgery (The)
Frampton Surgery
Frithwood Surgery
High Street Medical Centre (The)
Locking Hill Surgery
Marybrook Medical Centre
Minchinhampton Surgery
Painswick Surgery
Prices Mill Surgery
Regent Street Surgery
Rowcroft Medical Centre
Stonehouse Health Clinic
Stroud Valleys Family Practice
Walnut Tree Practice

Performance Report – an overview

Statement from the Accountable Officer – the performance of the organisation 2015/16

We have made significant progress this year in delivering on our strategic objectives working closely with local partners.

This includes:

- Building a sustainable and effective organisation with robust governance arrangements
- Developing strong leadership as commissioners
- Working with our partners and patients to develop and deliver ill health prevention and supporting people to take more control over their health and well-being
- Transforming services to meet the future needs of the population – including 'joining up care' across the health and social care community
- Enabling active communities and building strong networks of support
- Working with patients, carers and the public to inform decision making and develop services.

Building a sustainable and effective organisation with robust governance arrangements

We have approved our constitution and through the year have reviewed our sub-committees against the requirements for the CCG.

This year, we exercised delegated authority from NHS England for the commissioning of primary care services. In order to ensure sound governance processes, and avoid any conflicts of interest, a Primary Care Commissioning Committee was established, to oversee these commissioning responsibilities.

The NHS Constitution imposes a statutory duty on the CCG to have a priority setting system in place that explains how the CCG decides whether to fund a healthcare intervention or service. We also have a duty to publish the decision making process on our website.

As a result of this, we set up a Priorities Sub Committee and adopted an ethical framework and prioritisation framework.

Details of our Governance arrangements are set out in the Governance Statement in this Report.

We have also supported the development of our locality structure, providing management support to locality executive groups and devolving budgets for locality commissioning. Each locality has published a comprehensive Locality Development Plan setting out how they are meeting the needs of their local communities and describing future priorities.

The CCG has also discharged its duties under section 14R of the Health and Social Care Act 2012. The CCG has developed a quality strategy 'Our Journey for Quality.' This strategy underpins all service developments the CCG commissions and also the ongoing contract monitoring of providers. This enables the CCG to ensure that quality and safety improvement is driving clinical service redesign and also implicit within the contracting for existing services.

The CCG has developed a three year Strategy for Promoting Equality and Valuing Diversity, with an updated action plan setting out how we intend to discharge our duties under the Public Sector Equality Duty. This year, our annual equality report: An Open Culture, has been extended to include examples of how engagement with our local communities has helped to ensure that we provide equity of access and fair treatment, continuing to improve the quality of our services and achieve better health outcomes for everyone. The strategy, action plan (An Open Culture, 2015) are all available in the About us section of our website at www.gloucestershireccg.nhs.uk/about-us/equality-diversity/

Developing strong leadership as commissioners

We have further developed our leadership role in 2015/16.

This includes:

- Supporting the development of locality commissioning (see above)
- Leading the Gloucestershire Strategic Forum work programme
- Being an active partner on the Gloucestershire Health and Wellbeing Board and supporting the delivery plans on tackling health inequalities, improving mental health, reducing obesity, improving health and wellbeing into older age and reducing the harm caused by alcohol
- Playing an instrumental role on the Leadership Gloucestershire Board, including formulation of health and care related devolution proposals.

We are assessed on a quarterly basis by NHS England (CCG Assurance Framework 2015/16) and have been assured as a well led organisation.

Working with our partners and patients to develop and deliver ill health prevention and supporting people to take more control over their health and well-being

Over the last year, we have been working with our partners to co-ordinate action on prevention and help people to self-care.

This has involved working to stop people from becoming ill in the first place, to programmes that support people with long term conditions, such as diabetes and cardiovascular disease to better self-manage.

Our Facts4life programme provides a radical approach to health education by teaching children about healthy living and understanding how their bodies react to illness. We have also been working with our partners to support community weight management programmes and peer support programmes to increase people's knowledge, skills and confidence to live with their long term condition.

Following on from work started this year; in 16/17 we will be encouraging local businesses throughout the county to join a workplace wellbeing charter. The Charter is an award scheme that aims to encourage healthy environments that support the health and wellbeing of employees. We will also be looking at new innovative ways to support patients with diabetes better manage their condition using technology.

Transforming services to meet the future needs of the population – including 'joining up care' across the health and social care community

We have further developed our Clinical Programme Group (CPGs) approach in 2015/16. These groups bring together a range of healthcare professionals to plan and improve the patient's journey through care.

This year we have seen significant developments in eye health, diabetes, respiratory care, cancer, musculoskeletal and mental health services.

We have also invested in developments to increase capacity in planned care services and the range of out of hospital services available in GP surgeries and local communities.

We are working together in Gloucestershire in a joined up way to transform the quality of care, services and support we commission and provide to local people.

This year, we have strengthened joint commissioning arrangements with the local authority, invested further in integrated health and social care community teams in Gloucestershire; including piloting close working with mental health and the voluntary and community sector, and made significant strides in developing secure systems to join up patient information across services.

Although we believe good progress has been made, we recognise that if we are going to meet the challenges of a growing population with more complex needs, we will have to accelerate the pace of change and be even more ambitious and innovative in how we organise services and deliver care.

Enabling active communities and building strong networks of support

Under the auspices of the Gloucestershire Health and Wellbeing Board, we are leading arrangements with local partners to strengthen arrangements for enabling and empowering active communities. A steering group has

been established with senior representation from local councils, the voluntary and community sector, the office of the Police and Crime Commissioner and the NHS.

Also, through development of its locality commissioning arrangements, the CCG is collaborating with a range of local partners to develop networks of community support. For example, during 2014/15, social prescribing schemes were established in every CCG locality across Gloucestershire. This means that patients who present at their GP surgery, but do not necessarily have a clear medical can access sources of community advice and support.

Working with patients, carers and the public to inform decision making and develop services

Our Experience and Safety Team have provided excellent support and prompt responses to queries from members of the public through the CCG Patient Advice and Liaison Service.

We continue to work closely with Healthwatch Gloucestershire, who have been involved in over 30 CCG projects this year. Having taken on responsibility for commissioning primary medical services, we have built strong links with GP Practice Patient Participation Groups (PPGs). We have established a well-attended Gloucestershire PPG Network, which has looked at issues from primary care estates to sharing healthcare information.

We also involve a wide range of community partners, particularly those from the voluntary and community sector, when developing new services and approaches to improving health and wellbeing across all communities. All of our clinical programme groups are attended by patient representatives and Lay Champions.

All strategic changes are supported by comprehensive engagement and communication, including early 'no surprises' conversations with the NHS Reference Group, attended by representatives from the local Health and Care Overview and Scrutiny Committee and Healthwatch Gloucestershire.

Our Information Bus has visited all corners of the county, attending hundreds of events and promoting healthy messages including reducing mental health stigma, sexual health and smoking cessation, dementia research, and the ASAP, Combat Norovirus, Ask your Pharmacist and Safe & Well campaigns.

Our Performance

The CCG set a balanced budget at the start of the financial year with a planned surplus of £7.300m (which equates to 1% of our allocation, minimum requirement from NHS England to plan for as part of good financial management). At the end of the financial year the CCG has delivered a surplus of £9.456m. The surplus delivered is above the planned surplus to enable a number of new allocations to be carried forward to future years when they will be required. This is an achievement, in the context of the significant challenges we have set for ourselves around transforming the health system in Gloucestershire.

The CCG achieved its financial duties in 2015/16 as follows:

The CCG delivered an underspend of £9.456 million against its revenue resource limit, this included an underspend on its running cost allocation, as set out below:

Financial Summary	Programme Costs £m	Running Costs £m	£m
Revenue resource limit	797.386	14.068	811.454
Total net operating cost for the financial year	789.385	12.613	801.998
Surplus	8.001	1.455	9.456

The CCG received a capital resource limit in year for the replacement of IM&T equipment, the CCG's capital expenditure remained within its capital resource limit.

Financial Summary	£m
Capital resource limit	0.200
Capital expenditure for the financial year	0.151

In addition, the CCG

- Remained within its maximum cash drawdown as agreed with NHS England
- Complied with the Better Payments Practice Code (details provided within note 7.1 of the annual accounts).

The accounts as presented have been prepared under a Direction issued by the NHS Commissioning Board under the National Health Services Act 2006 (as amended).

As well as supporting innovation and new service improvements, the CCG also has a role in working with partners across our local health system to ensure that services deliver quality and safety, and meets national targets.

2015/16 has proved a challenging year for the NHS across the country, including areas such as A&E waits, ambulance response times and meeting the NHS Constitution pledge of Referral to Treatment for non-urgent care within 18 weeks.

Reducing demand on hospital services, particularly in urgent care, has been a key theme of our work this year.

We recognise there is more to do as a health and social care system to support Gloucestershire Hospitals NHS Foundation Trust in meeting the Accident and Emergency Department 4-hour waiting time standard for patients.

Gloucestershire has experienced pressure in all of these areas, but is working constructively with relevant providers to address the challenges we face using a range of measures. However, the NHS in Gloucestershire has continued to show good performance across a range of local and national standards including Referral to Treatment times.

Mary Hutton

Accountable Officer

26 May 2016

Performance Report

The purposes and activities of the organisation

NHS Gloucestershire CCG was established on the 1st April 2013 and is responsible for buying ('commissioning') services to meet the health needs of the population of Gloucestershire.

The CCG is a clinically led organisation with 81 GP member practices which help to shape health services based on evidence of what works best clinically, making best use of available resources and ensuring that patient safety and quality of services is paramount.

The CCG commissions a wide range of hospital, community, mental health, learning disability and primary care (GP) services.

A key role of the CCG is to work with health providers to ensure that they provide services that meet national and local service standards such as waiting times.

The CCG is placing greater emphasis on prevention, empowering people to self-manage their health conditions where appropriate and working with partners to develop active communities. By developing community services and support, the CCG and local partners aim to reduce the need for hospital stays, but work to ensure that safe, timely and effective hospital care is there when needed.

In addition, the CCG is increasingly focused on ensuring that patient experience and the effectiveness of services is a good as it can be.

The CCG works closely with other organisations that deliver services across Gloucestershire to ensure that planning is properly coordinated with, for example, social care, housing, the voluntary and community services. By doing this, the delivery and planning of health and social care services is effectively joined up with organisations working together to ensure high quality services and support to Gloucestershire residents.

Key issues and risk that could affect the entity in delivering its objectives

During the year, the CCG identified five risks graded as 'High'. Summarised details of these are given below:

- Non-delivery of the Constitution standard for a maximum wait of 4 hours within the emergency department
- Failure to comply with national and local access targets for planned care, including 2 week wait, over 52 week wait, 62 day cancer target, diagnostic 6-week target and planned follow-ups could result in inadequate and/or delayed care
- Potential fragmentation of the inpatient care pathway for children and young people with mental health problems and pressure on in-patient beds, in common with other parts of the country
- The CCG will be using the lead provider framework for the procurement of commissioning support services. This process may mean a different provider is chosen. This could result in disruption to services during the period of procurement and transition
- Risk of failing to achieve the emergency admission reduction in line with the QIPP plan.

No significant risks have been identified that specifically relate to:

- the effectiveness of governance structures
- the responsibilities of directors and committees
- reporting lines and accountabilities between the Governing Body, its committees and sub-committees and the executive team
- the submission of timely and accurate information to assess risks to compliance with the CCG's licence.

An explanation of the going concern

The CCG is required to give an explanation of its consideration of its status as a going concern.

This is effectively in relation to its intention to continue its operations for the foreseeable future and the awareness of any circumstances affecting this in its preparation of these financial statements.

The CCG has prepared a five year financial plan which shows the organisation achieving its financial duties in each of the respective years and has considered through its Audit Committee, the appropriateness of this approach; no issues were noted which would affect this. This is in addition to the Secretary of State direction that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern. As a result, the Governing Body of NHS Gloucestershire Clinical Commissioning Group has prepared these financial statements on a going concern basis.

Our performance highlights 2015/16

Performance against the NHS Constitution Indicators is given below with the standards being achieved:

	2015/16 Status	2016/17 forecast
Ensure that patients start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions	Green	Green
Two week wait for breast symptoms (where cancer was not initially suspected)	Green	Green
Cancer – first definitive* treatment within 31 days of a cancer diagnosis	Green	Green
Cancer – subsequent treatment for cancer within 31 days – surgery	Green	Green
Cancer – subsequent treatment for cancer within 31 days – drug regime	Green	Green
Cancer – subsequent treatment for cancer within 31 days – Radiotherapy	Green	Green
62 day wait for first treatment following referral from an NHS cancer screening service	Green	Green
62 day wait for first treatment for cancer following a consultant's decision to upgrade the patient priority	Green	Green
Dementia Diagnosis rate	Green	Green

** Definitive cancer treatment is having a plan designed to potentially cure cancer using one or a combination of treatments.*

There are some areas where the performance has fallen short of the required targets or standards in 2015/16 which require particular attention in the year ahead to improve performance. These are:

	2015/16 Status	2016/17 forecast
All cancer 2 week waits	Amber	Green
Ambulance clinical quality-Category A – 8 (Red 1) minute response	Amber	Green
Diagnostic test waiting times – under 6 week waits	Red	Green
Referral to Treatment pathways greater than 52 weeks	Red	Green
62 day cancer target (percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	Red	Green
Four hour A&E wait	Red	Red
Ambulance clinical quality-Category A - 8 (Red 2) minute response	Red	Green
Ambulance clinical quality – Category A 19 minute transportation time	Red	Green
Cancelled operations not rebooked within 28 days	Red	Green
Mixed sex accommodation breaches	Red	Green
Improving Access to Psychological Therapies (IAPT)* access and recovery rate	Red	Amber

*Improving Access to Psychological Therapies (IAPT) is an NHS programme offering interventions approved by the National Institute of Health and Clinical Excellence (NICE) for treating people with depression and anxiety disorders. Access rates relate to the number of people entering treatment over the level of need i.e. the number of people with depression and anxiety disorders in the population.

The tables above relate to NHS Constitution requirements. The method of calculation can be found at: ***www.england.nhs.uk/everyonecounts***

Referral to Treatment (RTT): The CCG has consistently met the target of 92% patients starting their consultant-led treatment within a maximum of 18 weeks from referral. Long waiters (those who have waited longer than 52 weeks to start their consultant led treatment) have predominantly occurred at specialist centres for patients with complex spinal/neurosurgical needs. The CCG has identified continued pressures within Cardiology, General Surgery and Urology. Plans are in place to redesign pathways (the patient's journey through care) in all of these areas to sustainably improve performance in the long term.

4 hour A&E wait: Delivery of this target has been very challenging, with key actions focused on discharge of patients from the hospital and ensuring that all providers involved in urgent care are working to ensure the most effective arrangements are in place for the patient.

The CCG continues to implement a programme to improve arrangements within urgent and emergency care services to ensure that the system can cope with peaks in demand. These actions are set out in our system resilience plans and focus upon self-care, signposting, admission avoidance (avoiding the need for a hospital stay), in-hospital care, hospital discharge (patients leaving hospital in a timely way when they are fit to do so) and community services. The CCG and Gloucestershire Hospitals NHS Foundation Trust are working closely with Monitor to improve the 4 hour position with plans in place to deliver 90% during Q3 and Q4 (2016/17).

Diagnostic waits: The proportion of patients waiting over 6 weeks for a diagnostic procedure has increased in 2015/16. Performance in the first six months was affected by the percentage of patients waiting more than 6 weeks for a diagnostic procedure in the areas of Endoscopy and Echocardiology. Both issues have been resolved following the implementation of agreed action plans. There is on-going concern regarding Neurophysiology and MRI capacity; with plans in place to reduce the number of people waiting more than 6 weeks.

Cancer waiting times: Delivery of cancer targets has been pressured with increased demand for services throughout 2015/16. The CCG has co-ordinated a GP education programme during 2015/16 and has developed a Living With and Beyond Cancer programme with Macmillan.

Mental health targets: The CCG has improved dementia diagnosis rates from 62% to 67% with a continued commitment to meet the 66.7% standard in 2016/17.

During 2015/16 access to psychological therapies was increased; however, there have been issues identified with the recovery rate of those entering into IAPT. Access to psychological therapies is to be maintained in 2016/17 at 15%, which is in line with the national target. The CCG is working with 2gether NHS Foundation Trust and the national IAPT leads to enable a significant improvement in the number of service users achieving recovery with the aim to increase performance from 34% to 50% by the end of 2016/17. The CCG is expecting official feedback from the national intensive support team in June 2016 and will work with all stakeholders to implement the recommendations.

Quality Premium

The Quality Premium is intended to reward the CCG for improvements in the quality of the services that we commission and for associated improvements in health outcomes and reducing inequalities. The Quality Premiums paid to the CCG in 2015/16 were based on the following agreed indicators and performance in 2014/15:

Domain	Description	Achievement
1.Preventing people from dying prematurely	Reducing premature mortality: Reduction of potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people	**Not Achieved**
2.Enhancing quality of life for people with long term conditions	Improving access to psychological therapies (IAPT)	**Achieved**
2. Enhancing quality of life for people with long-term conditions & 3. Helping people to recover from episodes of ill health or following injury	Avoidable emergency admissions - Composite measure of: a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) b) unplanned hospitalisation for asthma, diabetes and epilepsy in children c) emergency admissions for acute conditions that should not usually require hospital admission (all ages) d) emergency admissions for children with lower respiratory tract infection.	**Achieved**
4. ensuring that people have a positive experience of care	1. Improve patient experience of hospital care 2. Show improvement in average Friends and Family Test (FFT) scores between Q4 13/14 & Q4 14/15	**Not Achieved**
Local Indicator	Improved reporting of medication-related safety incidents	**Achieved**
Local Indicator	Reduction in the Emergency admissions for children with lower respiratory tract infections (LRTIs)	**Achieved**

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in the following key indicators;

NHS Constitution Indicator	Achievement
Ensure that patients start their consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions	**Not Achieved**
Four hour A&E target	**Not Achieved**
Ambulance clinical quality – Category A – 8 (Red 1) minute response	**Achieved**
Maximum two week (14-day) wait from urgent GP referral to first outpatient appointment for suspected cancer.	**Not Achieved**

CCG Assurance Framework 2015/16

All CCG's are assessed on a quarterly basis by Area Teams of NHS England against a set of domains / indicators based on a standardised framework

Domain	Q1	Q2	Q3	Q4 forecast
Well led organisation	Assured	Assured	Assured	Assured
Delegated Functions	Assured	Assured	Assured	Assured
Financial Management	Assured	Assured	Assured	Assured
Performance	Limited Assurance	Limited Assurance	Limited Assurance	Limited Assurance
Planning	Assured	Assured	Assured	Assured

Sustainable development

NHS Gloucestershire CCG is committed to using a sustainable approach to commissioning healthcare services and working within the available environmental and social resources; protecting and improving health now and for future generations.

To this effect, we are working to reduce carbon emissions, minimise waste and pollution, make the best use of scarce resources, build resilience to a changing climate and nurture community strengths and assets.

We work with our partners and stakeholders to embed sustainability and carbon reduction into everything we do; from our internal activities to commissioning frontline services in the communities we serve.

Our sustainable development policy was reviewed and extended to include the national policy updates at our Integrated Governance and Quality Committee in October.

The CCG's Director of Nursing & Governance takes responsibility for Sustainability at Board level. Internally we take action on sustainability through our Joint Staff Consultative Forum which reviews a sustainability topic each month.

The CCG recognises that the majority of its carbon emissions derive from our commissioning activity. As such, we support sustainability improvements across our provider trusts by offering sustainability advice and working with our largest provider trusts to share best practice and benchmark performance as part of a quarterly sustainability forum.

All providers are asked to demonstrate their plans and policies on sustainability as part of our contracting processes.

Accountability Report – corporate governance report

Member's Report

- Names of Chair and Accountable Officer – included in Annual Governance Statement
- Management Board - included in Annual Governance Statement
- Names of Audit Committee members – included in Annual Governance Statement
- Register of Interests – available at www.gloucestershireccg.nhs.uk/about-us/transparency
- Personal Data incidents – none- comment included in Annual Governance Statement

Statement of disclosure to auditors

Each individual who is a member of the Governing Body at the time the Members' Report is approved confirms:

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

Remuneration Report for NHS Gloucestershire CCG 2015-16

Name & Title	2015-16						
	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £5,000)	Sub-toal (bands of bands)	All Pension Related Benefits (bands of £2,500)*	Total (bands of £5,000)
Dr Helen Miller, Clinical Chair	85-90	-	-	-	85-90	7.5-10	90-95
Dr Andrew Seymour, Deputy Clinical Chair	80-85	-	-	-	80-85	7.5-10	90-95
Mary Hutton, Accountable Officer	140-145	-	-	-	140-145	10-12.5	150-155
Mark Walkingshaw, Deputy Accountable Officer/Director of Commissioning Implementation	105-110	-	-	-	105-110	-	105-110
Cath Leech, Chief Finance Officer	100-105	-	-	-	100-105	15-17.5	120-125
Ellen Rule, Director of Transformation and Service Redesign	100-105	-	-	-	100-105	22.5-25	120-125
Helen Goodey, Director of Primary Care and Locality Development (from 19/06/2015)	75-80	-	-	-	75-80	22.5-25	100-105
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	40-45	-	-	-	40-45	10-12.5	55-60
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	20-25	-	-	-	20-25	-	20-25
Dr Malcolm Gerald, Clinical Commissioning Lead (South Cotswolds)	40-45	-	-	-	40-45	-	40-45
Dr Martin Gibbs, Clinical Commissioning Lead (Forest Of Dean) (to 31/05/15	5-10	-	-	-	5-10	-	5-10
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	40-45	-	-	-	40-45	-	40-55
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)	40-45	-	-	-	40-45	-	40-45
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	40-45	-	-	-	40-45	90-92.5	135-140
Dr Tristan Lench, Clinical Commissioning Lead (Forest of Dean) (From 09/04/15)	40-45	-	-	-	40-45	7.5-10	50-55
Dr Sadaf Haque, GP Liaison Lead (From 01/06/15)	20-25				20-25	5-7.5	30-35
Julie Clatworthy, Registered Nurse	15-20	-	-	-	15-20	-	15-20
Dr Marion Andrews-Evans – Executive Nurse & Quality Lead	100-105	-	-	-	100-105	-	100-105
Alan Elkin, Lay Member, Patient and Public Engagement/Involvement	15-20	-	-	-	15-20	-	15-20
Colin Greaves, Lay Member, Governance	15-20	-	-	-	15-20	-	15-20
Valerie Webb, Lay Member, Business	5-10	-	-	-	5-10	-	5-10
Joanna Davies, Lay Member (From 01/12/15)	0-5	-	-	-	0-5		0-5
Dr Raju Reddy, Secondary Care Clinical Advisor (From 1/11/15)	Payment is made to Dr Reddy's host Trust (Birmingham Childrens NHS Foundation Trust)						
Sarah Scott, Director of Public Health at Gloucestershire County Council	No payment is received from NHS Gloucestershire CCG						
Margaret Willcox, Director of Adult Social Care at Gloucestershire County Council	No payment is received from NHS Gloucestershire CCG						

* These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme. These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

Remuneration Report for NHS Gloucestershire CCG 2014-15

Name & Title	2014-15						
	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £5,000)	Sub-toal (bands of bands)	All Pension Related Benefits (bands of £2,500)*	Total (bands of £5,000)
Dr Helen Miller, Clinical Chair	85-90	-	-	-	85-90	0-2.5	85-90
Dr Andrew Seymour, Deputy Clinical Chair	80-85	-	-	-	80-85	5-7.5	85-90
Mary Hutton, Accountable Officer	140-145	-	-	-	140-145	2.5-5	140-145
Mark Walkingshaw, Deputy Accountable Officer/Director of Commissioning Implementation	110-115	-	-	-	110-115	-	110-115
Cath Leech, Chief Finance Officer	105-110	-	-	-	105-110	-	105-110
Ellen Rule, Director of Transformation and Service Redesign (from 02/06/2014)	75-80	-	-	-	75-80	5-7.5	80-85
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	45-50	-	-	-	45-50	72.5-75	115-120
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	20-25	-	-	-	20-25	-	20-25
Dr Malcolm Gerald, Clinical Commissioning Lead (South Cotswolds)	45-50	-	-	-	45-50	-	45-50
Dr Martin Gibbs, Clinical Commissioning Lead (Forest Of Dean)	45-50	-	-	-	45-50	22.5-25	65-70
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	45-50	-	-	-	45-50	-	45-50
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)	45-50	-	-	-	45-50	25-27.5	70-75
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	45-50	-	-	-	45-50	7.5-10	50-55
Julie Clatworthy, Registered Nurse	20-25	-	-	-	20-25	-	20-25
Dr Marion Andrews-Evans – Executive Nurse & Quality Lead	95-100	-	-	-	95-100	-	95-100
Alan Elkin, Lay Member, Patient and Public Engagement/Involvement	15-20	-	-	-	15-20	-	15-20
Colin Greaves, Lay Member, Governance	15-20	-	-	-	15-20	-	15-20
Valerie Webb, Lay Member, Business	5-10	-	-	-	5-10	-	5-10
Steve Allder, Secondary Care Clinical Advisor	Payment is made to Dr Allder's host Trust (Plymouth Hospitals NHS Trust)						
Dr Peter Brambleby, Interim Director of Public Health at Gloucestershire County Council	No payment is received from NHS Gloucestershire CCG						
Margaret Willcox, Director of Adult Social Care at Gloucestershire County Council	No payment is received from NHS Gloucestershire CCG						

* These figures are purely the benefits accruing to senior managers from membership of the NHS Pensions Scheme. These are the aggregate input amounts, calculated using the method set out in section 229 of the Finance Act 2004(1). Para 10(1)(e)(ii)(cc) of sch8 of 2013/1981 (update to the Finance Act 2004):

Pensions Report 2015-16

Pensions Report for NHS Gloucestershire CCG 2015-16 Name & Title	Real increase in pension at age 60 (Bands of £2,500)	Real increase in pension lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60 at 31 March 2016 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2016 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000	Employer's contribution to partnership pension £000
Dr Helen Miller, Clinical Chair	0-2.5	2.5-5	15-20	50-55	338	23	365	12
Dr Andrew Seymour, Deputy Clinical Chair	0-2.5	2.5-5	10-15	30-35	167	18	187	12
Mary Hutton, Accountable Officer	0-2.5	2.5-5	30-35	95-100	605	35	646	20
Mark Walkingshaw, Deputy Accountable Officer/Director of Commissioning Implementation	0-2.5	0-2.5	25-30	85-90	457	10	472	16
Cath Leech, Chief Finance Officer	0-2.5	(0-2.5)	30-35	90-95	526	18	550	15
Ellen Rule, Director of Transformation and Service Redesign	0-2.5	(0-2.5)	15-20	40-45	185	15	202	14
Helen Goodey, Director of Primary Care and Locality Development (from 19/06/15)	0-2.5	0-2.5	10-15	35-40	197	20	225	11
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	0-2.5	0-2.5	10-15	35-40	205	17	225	6
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	0-2.5	0-2.5	15-20	55-60	412	7	423	3
Dr Malcolm Gerald, Clinical Commissioning Lead (South Cotswolds)	Dr Gerald has opted out of the NHS pension scheme							
Dr Martin Gibbs, Clinical Commissioning Lead (Forest Of Dean) (to 31/05/15)		Dr Gibbs retired from the NHS on the 31st May 2015 and there are no values for 31st March 2016						
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	0-2.5	(0-2.5)	10-15	35-40	215	8	226	6
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)	(0-2.5)	(2.5-5)	5-10	15-20	95	8	104	6
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	5-7.5	(32.5-35)	15-20	0	139	9	150	6
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead	Dr Andrews-Evans has opted out of the NHS pension scheme							
Dr Sadaf Haque, GP Liaison Lead (from 01/06/15)	0-2.5	0	0-5	0	0	3	4	4
Dr Tristan Lench, Clinical Commissioning Lead (Forest of Dean) (from 09/04/15)	0-2.5	0	0-5	0	0	7	7	6
Dr Raju Reddy, Secondary Care Clinical Advisor (From 1/11/15)	Dr Reddy is not an employee of NHS Gloucestershire CCG and payment is made to his host Trust (Birmingham Childrens NHS Foundation Trust)							

Pensions Report 2014-15

Pensions Report for NHS Gloucestershire CCG 2014-15 Name & Title	Real increase in pension at age 60 (Bands of £2,500)	Real increase in pension lump sum at aged 60 (Bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2015 £000	Employer's contribution to partnership pension £000
Dr Helen Miller, Clinical Chair	0-2.5	0-2.5	15-20	50-55	307	22	338	12
Dr Andrew Seymour, Deputy Clinical Chair	0-2.5	0-2.5	5-10	25-30	144	19	167	11
Mary Hutton, Accountable Officer	0-2.5	2.5-5	25-30	85-90	554	36	605	19
Mark Walkingshaw, Deputy Accountable Officer/Director of Commissioning Implementation	0-2.5	0-2.5	25-30	85-90	424	21	457	15
Cath Leech, Chief Finance Officer	0-2.5	0-2.5	30-35	90-95	490	23	526	15
Ellen Rule, Director of Transformation and Service Redesign	0-2.5	0-2.5	10-15	40-45	166	12	185	11
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	2.5-5	10-12.5	12.5-15	35-40	145	57	205	6
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	(0-2.5)	(0-2.5)	15-20	50-55	394	7	412	3
Dr Malcolm Gerald, Clinical Commissioning Lead (South Cotswolds)								
Dr Martin Gibbs, Clinical Commissioning Lead (Forest Of Dean)	0-2.5	2.5-5	15-20	45-50	270	36	313	6
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	0-2.5	0-2.5	10-15	35-40	199	10	215	6
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)	0-2.5	5-7.5	5-10	15-20	74	19	95	8
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	0-2.5	0-2.5	10-15	30-35	124	12	139	6
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead								
Steve Allder, Secondary Care Clinical Advisor	Dr Allder is not an employee of NHS Gloucestershire CCG and payment is made to his host Trust (Plymouth Hospitals NHS Trust)							

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

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

Real Increase in CETV

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

Annual Governance Statement

Introduction and context

The Clinical Commissioning Group (CCG) was licenced from 1 April 2013 under provisions enacted in the Health and Social Care Act 2012, which amended the National Health Service Act 2006.

As at 1 April 2015, the CCG was licensed without conditions.
The vision of the CCG is to achieve improved health and well-being for the people of Gloucestershire through joined up care and communities.

To improve health and well-being, we believe that by all working better together – in a more joined up way – and using the strengths of individuals, carers and local communities, we will transform the quality of care and support we provide to all local people.

Scope of responsibility

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

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

Compliance with the UK Corporate Governance Code

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

During the year there has been a focus on ensuring that our policy and processes for the management of potential conflicts of interest are sound and reflect best practice. This has been particularly important during 2015/16, as the CCG took on responsibility for commissioning primary care services.

The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:
The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

The Constitution of the CCG establishes the principles and values in commissioning care for the people of Gloucestershire. The Constitution outlines the governance structure of the organisation and details the role and responsibilities of the Governing Body, its members and sub-committees.

The Governing Body has the functions conferred on it by sections 14L(2) and (3) of the 2006 Act, inserted by section 25 the 2012 Act, together with any other functions connected with its main functions as may be specified in regulations. The Governing Body:

a. ensures the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance
b. determines the remuneration, fees and other allowances payable to employees or other persons providing services to the CCG and the allowances payable under any pension scheme it may establish under paragraph 11(4) of Schedule 1A of the 2006 Act, inserted by Schedule 2 of the 2012 Act
c. approves any functions of the CCG that are specified in regulations that the membership will delegate to their Governing Body
d. ensures that the register of interests is reviewed regularly, and updated as necessary
e. ensures that all conflicts of interest or potential conflicts of interest are declared.

Governance Statement

During the year, the Governing Body comprised the following members:

- CCG Clinical Chair (Helen Miller)
- Deputy Clinical Chair (Andy Seymour)
- GP Member (Caroline Bennett)
- GP Member (Charles Buckley)
- GP Member (Malcolm Gerald)
- GP Member (Martin Gibbs – ceased 31st May 2015)
- GP Member (Tristan Lench – commenced 9th April 2015)
- GP Member (Will Haynes)
- GP Member (Hein Le Roux)
- GP Member (Jeremy Welch)
- GP Member (Sadaf Haque – commenced 1st June 2015)
- Accountable Officer (Mary Hutton)
- Chief Finance Officer (Cath Leech)
- Director of Public Health (Sarah Scott)
- Director of Adult Social Care (Margaret Willcox)
- Registered Nurse (Julie Clatworthy)
- Secondary Care Specialist (Raju Reddy – commenced 1st November 2015)
- Vice Chair and Lay Member – Patient and Public Engagement (Alan Elkin)
- Lay Member – Governance (Colin Greaves)
- Lay Member – Business (Valerie Webb)
- Lay Member – Patient and Public Engagement (Jo Davies – commenced 1st December 2015)
- Executive Nurse and Quality Lead (Marion Andrews-Evans)
- Director of Commissioning Implementation (Mark Walkingshaw)
- Director of Transformation and Service Redesign (Ellen Rule)
- Director of Locality Development and Primary Care (Helen Goodey – commenced 19th June 2015)

The terms of reference for the Governing Body, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The Governing Body has established the following five committees:

- Audit Committee
- Remuneration Committee
- Integrated Governance and Quality Committee
- Priorities Committee
- Primary Care Commissioning Committee.

The Audit Committee provides the Governing Body with an independent and objective view of the Clinical Commissioning Group's financial risk, financial systems, financial information and compliance with laws, regulations and directions governing the organisation in so far as they relate to finance. The Terms of Reference were amended during the year in order to include the role of Auditor Panel.

The Audit Committee comprises the following members:

- Lay Member – Governance, Audit Committee Chair (Colin Greaves)
- Deputy Clinical Chair (Andy Seymour)
- GP Member (Hein Le Roux)
- Lay Member – Business (Valerie Webb)
- Vice Chair and Lay Member – Patient and Public Engagement (Alan Elkin)

The terms of reference for the Audit Committee, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The Remuneration Committee considers the remuneration, fees and other allowances for employees and for people who provide services to the Clinical Commissioning Group and regarding allowances under any pension scheme that the Group may establish as an alternative to the NHS pension scheme.

The Remuneration Committee comprises the following members:

- Vice Chair, Lay Member – Patient and Public Engagement, Remuneration Committee Chair (Alan Elkin)
- CCG Clinical Chair (Helen Miller)
- Deputy Clinical Chair (Andy Seymour)
- GP Member (Jeremy Welch)
- Lay Member - Governance (Colin Greaves)
- Lay Member – Business (Valerie Webb)
- Lay Member – Patient and Public Engagement (Jo Davies – commenced 1st December 2015)

The terms of reference for the Remuneration Committee, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The role of the Integrated Governance and Quality Committee is to ensure that controls and processes are in place to continuously improve the delivery of healthcare services to the people of Gloucestershire, so ensuring that the services are of high quality, clinically effective and safe, within available resources. The Committee ensures that controls are in place and are operating efficiently and effectively to deliver the principal objectives of the Governing Body and to set in place processes to manage identified risks, minimising the Clinical Commissioning Group's exposure to corporate, and clinical risks. The Committee has a pro-active approach to the management of risk and quality, ensuring the organisation learns and takes appropriate corrective action.

The Integrated Governance and Quality Committee (IGQC) comprises the following members:

- Registered Nurse and IGQC Chair (Julie Clatworthy)
- CCG Clinical Chair (Helen Miller)
- GP Member (Caroline Bennett)
- GP Member (Charles Buckley)
- GP Member (Malcolm Gerald)
- GP Member (Martin Gibbs – ceased 31st May 2015)
- GP Member (Tristan Lench – commenced 9th April 2015)
- Accountable Officer (Mary Hutton)
- Chief Finance Officer (Cath Leech)
- Director of Public Health (Sarah Scott)
- Lay Member – Governance (Colin Greaves)
- Lay Member – Business (Valerie Webb)
- Vice Chair and Lay Member – Patient and Public Engagement (Alan Elkin)
- Executive Nurse and Quality Lead (Marion Andrews-Evans)
- Director of Commissioning Implementation and Deputy Accountable Officer (Mark Walkingshaw)

The terms of reference for the Integrated Governance and Quality Committee, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The purpose of the Priorities Committee is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority. The Priorities Committee helps the Clinical Commissioning Group and its Localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment.

The Priorities Committee comprises the following members:

- CCG Clinical Chair and Priorities Committee Chair (Helen Miller)
- Deputy Clinical Chair (Andy Seymour)
- GP Member (Caroline Bennett)
- GP Member (Charles Buckley)
- GP Member (Malcolm Gerald)
- GP Member (Martin Gibbs – ceased 31st May 2015)
- GP Member (Tristan Lench – commenced 9th April 2015)
- GP Member (Will Haynes)
- GP Member (Hein Le Roux)
- GP Member (Jeremy Welch)
- GP Member (Sadaf Haque – commenced 1st June 2015)
- Accountable Officer (Mary Hutton)
- Chief Finance Officer (Cath Leech)
- Director of Public Health (Sarah Scott)
- Director of Adult Social Care (Margaret Willcox)
- Registered Nurse (Julie Clatworthy)

- Secondary Care Specialist (Raju Reddy – commenced 1st November 2015)
- Vice Chair and Lay Member – Patient and Public Engagement (Alan Elkin)
- Lay Member – Governance (Colin Greaves)
- Lay Member – Business (Valerie Webb)
- Lay Member – Patient and Public Engagement (Jo Davies – commenced 1st December 2015)
- Executive Nurse and Quality Lead (Marion Andrews-Evans)
- Director of Commissioning Implementation (Mark Walkingshaw)
- Director of Transformation and Service Redesign (Ellen Rule)
- Director of Locality Development and Primary Care (Helen Goodey – commenced 19th June 2015)

The terms of reference for the Priorities Committee, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The purpose of the Primary Care Commissioning Committee is to manage the delivery of those elements of the primary care healthcare services delegated by NHS England to the Clinical Commissioning Group working within the context of the overall Clinical Commissioning Group Plan. The Committee seeks to ensure that the people of Gloucestershire receive primary care services that are of high quality, clinically effective and safe, within available resources.

The Primary Care Commissioning Committee (PCCC) comprises the following members:

- Lay Member – Patient and Public Engagement and PCCC Chair (Alan Elkin)
- Lay Member – Governance (Colin Greaves)
- Accountable Officer (Mary Hutton)
- Chief Finance Officer (Cath Leech)
- Executive Nurse and Quality Lead (Marion Andrews-Evans)
- Registered Nurse (Julie Clatworthy)
- GP Member (Andy Seymour)

In addition to the above, the following are invited to meetings as non-voting attendees:

- Healthwatch representative
- Health and Wellbeing representative
- NHS England Area Team representatives

The terms of reference for the Primary Care Commissioning Committee, contained within the Constitution, states the quorum for meetings, which was achieved on all occasions.

The guidance contained within the UK Corporate Governance Code (Sept 2012) and the NHS CCG Code of Governance (Nov 2013) has been followed. I consider that the organisation complies with the principles and standards of best practices.

The arrangements in place for the discharge of statutory functions have been reviewed for any irregularities as part of the internal and external audit work and are considered to be legally compliant. Further assurance has been obtained through the work of the Accountable Officer, Chief Finance Officer, the Governing Body and the Audit Committee.

The Clinical Commissioning Group has followed guidance issued by NHS England on the role and powers of clinical commissioning groups and employs experienced and well qualified staff. Legal advice and the views of the NHS England Local Area Team have been sought to obtain clarification and interpretation of laws, regulations and guidance, where appropriate.

The Clinical Commissioning Group Risk Management Framework

The risk and control framework is outlined in the Clinical Commissioning Group's Risk Management Policy. This document, along with the Risk Management Procedure, provides guidance on:

- risk identification
- risk analysis and assessment
- risk treatment and control
- risk reporting
- communication and training
- monitoring and review.

Directorate Risk Registers are maintained which are amalgamated into, and from, the Corporate Risk Register. The management of identified risks is the responsibility of nominated managers. The Corporate Risk Register is presented to the bi-monthly meetings of the Integrated Governance and Quality Committee, where the acceptability of the risk and the adequacy of the action plans are considered.

The more significant strategic risks are also included in the Assurance Framework which is presented regularly to meetings of both the Integrated Governance and Quality Committee and the Governing Body. The primary function of the Assurance Framework is to outline the assurances that will be provided to the Governing Body regarding the achievement of the organisation's Annual Objectives.

The risk management processes, outlined in the Risk Management Policy and Procedure, and the risk reporting structure ensures that risk management has a high-profile in the organisation and is considered as an integral part of the organisation's activities.

An ethical framework has been developed to support the Clinical Commissioning Group's decision making process. All service change proposals are subject to equality impact assessments, the outcomes of which are considered as part of the decision making process. All senior staff have had training in undertaking equality impact assessments. In addition, all staff are required to undertake on-line equality and diversity training.

The Clinical Commissioning Group is regularly in contact with approximately 1,400 local public stakeholders through its stakeholder database. Stakeholders are invited to participate in engagement and consultation activities regarding proposed changes to services and are also invited to inform the procurement or re-procurement of services.

Identified risks are assessed by the responsible managers in terms of likelihood and significance, using the matrix recommended by the National Patient Safety Agency.

During the year, six risks graded as 'High' were identified by Clinical Commissioning Group managers. Summarised details of these are given below:

- Non-delivery of the Constitution standard for maximum wait of 4 hours within the emergency department
- Failure to comply with national and local access targets for planned care, including 2 week wait, over 52 week wait, 62 day cancer target, diagnostic 6-week target, planned follow-ups could result in inadequate and/or delayed care
- Potential fragmentation of the inpatient care pathway for children and young people with mental health problems and pressure on inpatient beds, in common with other parts of the country
- The CCG will be using the lead provider framework for the procurement of commissioning support services. This process may mean a different provider is chosen. This could mean disruption to services during the period of procurement and transition
- Risk of failing to achieve the emergency admission reduction in line with the QIPP plan
- Risk to financial performance if prescribing costs are in excess of the agreed budget.

No significant risks have been identified that specifically relate to:

- the effectiveness of governance structures
- the responsibilities of directors and committees
- reporting lines and accountabilities between the Governing Body, its committees and sub-committees and the executive team
- the submission of timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's licence.

The Clinical Commissioning Group 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.

Appended to the Clinical Commissioning Group's Constitution are the following documents that form the basis of the internal control systems embedded within the organisation:

- Standing Orders
- Scheme of Reservation and Delegation
- Detailed Scheme of Delegation
- Prime Financial Policies.

The Chief Finance Officer reports on any risks to the financial position of the Clinical Commissioning Group at each meeting of the Governing Body. The Governing Body has also received updates on progress with the agreed QIPP efficiency programmes which are integral to the delivery of the financial plans.

Miscellaneous matters such as single tender actions and losses and special payments are reported to the Audit Committee.

The Audit Committee provides the Governing Body with an independent and objective view of the Group's financial systems, financial information and compliance with laws, regulations and directions governing the Group insofar as they relate to finance. The Governing Body has approved, and keeps under review, the terms of reference for the Audit Committee.

Information Governance

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

The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the CCG, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

Information risk management is integrated with the CCG overall risk management strategy, and compliance with the Health and Social Care Information Centre Information Governance Toolkit ensures all key information security risks are monitored and controlled. Via its informatics providers: South, Central and West Commissioning Support Unit (CSU) and Countywide IT Services, the Clinical Commissioning Group operates secure information networks and systems. New systems and processes are assessed by governance and information security staff at the point of design or procurement, and appropriate safeguards to minimise risk are put in place. Incidents are reported on an online reporting tool and monitored by the CSU's governance team with input from Information Governance and Information Security experts as required.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have

implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for 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.

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

The Clinical Commissioning Group's Standing Orders and Prime Financial Policies form the foundation of the control structure that ensures resources are used economically, efficiently and effectively. These documents are supplemented by budgetary control and other financial policies and procedures.

The internal audit service reviews core financial systems and budgetary control provided assurance regarding these processes.

A detailed performance report is provided to each scheduled meeting of the Governing Body. These reports provide an overview of the CCG compliance against the organisational objectives and financial targets.

The services commissioned are being constantly monitored to ensure they are appropriate and of a good quality by way of the service redesign processes and QIPP monitoring.

The CCG is working in partnership with Gloucestershire County Council to manage both the Better Care Fund (a budget for health and social care services to encourage closer working arrangements between the NHS and the Local Authority) and other partnership budgets. The operation of the Better Care Fund is considered as part of the performance monitoring report received at every formal meeting of the Governing Body. The arrangement is governed by a Section 75 agreement signed off by both organisations.

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

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

Capacity to Handle Risk

The management of identified risks is the responsibility of nominated managers. As stated above, the Corporate Risk Register is presented to the bi-monthly meetings of the Integrated Governance and Quality Committee where the adequacy of the risk assessments is considered. The more significant strategic risks are also included in the Assurance Framework which is presented regularly to meetings of both the Integrated Governance and Quality Committee and the Governing Body.

Appended to the Risk Management Policy is a detailed Risk Management Procedure which provides full guidance to managers and staff regarding the identification, recording and management of risks. The Risk Management Policy is available to all members of staff via the CCG intranet.

Review of Effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the 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 my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and risk/ clinical governance/ quality committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The CCG has a nominated Local Counter Fraud Specialist who provides a report on counter fraud activity to each meeting of the Audit Committee.

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:

We are satisfied that sufficient internal audit work has been undertaken to allow an opinion to be given as to the adequacy and effectiveness of governance, risk management and control. In giving this opinion, it should be noted that assurance can never be absolute. The most that the internal audit service can provide is reasonable assurance that there are no major weaknesses in the system of internal control.

Opinion

Our opinion is as follows:

Governance, risk management and control in relation to business critical areas is generally satisfactory. However, there are some areas of weakness and non-compliance in the organisation's system of internal control which potentially put the achievement of objectives at risk. The CCG has either implemented or has action plans in place to implement the recommendations raised during the year. Some improvements are required in those areas to enhance the adequacy and effectiveness of the organisation's system of internal control.

Basis of opinion

Our opinion is based on:

- All audits undertaken during the year
- Any follow up action taken in respect of audits from previous periods
- Any significant recommendations not accepted by management and the resulting risks
- The effects of any significant changes in the organisation's objectives or systems
- Any limitations which may have been placed on the scope or resources of internal audit
- What proportion of the organisation's audit needs have been covered to date.

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Commentary

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

- To date we have completed all 11 of the internal audit reviews in the 2015/16 internal audit plan for the year ended 31 March 2016. Our work to date has identified 19 Low, 10 medium, 3 high and 0 critical risk rated findings
- The overall classification for the Business Continuity Process review was high risk. Findings related to a Business Impact Analysis, or Critical Functions Analysis, having not been undertaken across the business teams within the CCG, and resource requirements have not been defined (high risk), no Crisis Management plan in place, exercising not being performed specific to the CCG and disruptions which affect the continuity of the CCG services provided and no Business Continuity Policy in place specific for the CCG. The CCG has implemented all of these recommendations prior to the year end
- The overall classification for Continuing Healthcare (CHC) was high risk. Findings related to a number of instances of non-compliance with CHC/FNC processes around lack of ongoing case review (17/25); a number of instances where there was insufficient documentation on CareTrack; Performance against 28 days key performance indicator (KPI) not being met in 9 out of 21 instances with the time taken ranging from 34 to 51 days. Domiciliary Care Invoices did not match to CareTrack for 17 out of 21 cases. There was no evidence that the invoices had been checked prior to payment

- We did not classify any other internal audit reports as high risk and we did not identify any individual high risk findings in our other internal audit reviews
- The CCG has implemented a number of the recommendations raised during 2015/16 and has action plans in place to implement those that have not been implemented by 31 March 2016.

Data Quality

A detailed performance report is presented to each bi-monthly meeting of the Governing Body and is available, along with all public Governing Body meeting papers, on the CCG's website. All information provided to the Governing Body and membership is subject to rigorous internal scrutiny prior to issue. The governance processes have also been the subject of an internal audit review. No adverse comments have been received regarding the accuracy of the information provided by the Governing Body, member practices or the internal auditors.

Business Critical Models

An appropriate framework and environment is in place within the CCG to provide quality assurance of business critical models, in line with the recommendations in the Macpherson report.

Data Security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

No Serious Incidents have been reported by the CCG relating to data security breaches.

Discharge of Statutory Functions

Arrangements put in place by the CCG and explained within the corporate governance framework have been developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

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

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

Conclusion

No significant internal control issues have been identified during 2015/16.

Mary Hutton

Accounting Officer

26 May 2016

Staff Report

NHS Gloucestershire CCG is a significant employer and larger than most CCGs. The workforce is made up of employees from a wide variety of professional backgrounds, in many cases in small numbers and a large proportion of employees sit within the management delivery team.

In building effective and meaningful partnership working with staff and staff side representatives, the CCG has developed partnership arrangements that are sufficiently flexible to accommodate and reflect the workforce in terms of professional group and size.

The CCG recognises all of the trade unions outlined in the Agenda for Change terms and conditions handbook who have members employed by the organisation.

Local arrangements are determined on an ad hoc basis where formal staff consultation is required, to ensure appropriate and effective consultation arrangements are in place.

The approach has worked well and an Organisational Development Group and Staff Consultative Forum are in place to consider staff issues and ensure effective communication with the workforce. Arrangements for formal staff consultation may be reviewed in light of the Business Plan to consider where arrangements may be further strengthened going forward.

The CCG has delegated negotiations over HR policy development to the SCW CSU Staff Partnership Forum (SPF). The SPF considers collated feedback from the CCG as part of this process and ensures staff and trade unions are equally engaged in the development process.

Policies are formally reviewed both by the Executive Management Team and by a Policy Review Group, before being ratified and adopted by the CCG's Integrated Governance & Quality Committee prior to publication.

The CCG has an organisational development plan (currently under review), which sets out how the organisation and individuals within it will progress to full capability.

The CCG is adopting a policy of visible and accessible leadership, with senior management engaging with staff. Examples include:

- Monthly face to face Team Briefing sessions (led by the Accountable Officer and Clinical Chair). This is supported by a written Team Brief e-bulletin which is then distributed and discussed within individual Directorate team meetings
- Introduction of a monthly Staff Awards. The presentation is held at the above session
- All CCG Staff Events – interactive workshop style sessions engaging staff in the development of the organisation. This year staff were fully involved in development of the CCG's refreshed Vision and Values
- Establishment of a CCG Staff Consultative Forum to engage staff representatives on key developments and to enhance levels of communication
- Development of 'CCG Live,' a website that holds information on all team briefs, policies, procedures and other information
- A monthly coffee morning (half hour), hosted on rotation by each department attended by CCG staff and directors to ensure strong networking and sharing of work related information across Directorates
- The CCG Executive Team meets with senior managers regularly.

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

Sickness absence data

Details of the level of sickness absence are given in note 5.3 in the Financial Statements. The organisation has an approved policy and associated procedure to help with the management of sickness absence.

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

Managers ensure that the culture of sickness reporting is embedded within their teams and sickness absence is actively monitored and formally reported to the CCG's Integrated Governance & Quality Committee on a quarterly basis as part of the workforce reporting mechanism. This committee includes both Lay Members & Executive Directors of the CCG.

Staff sickness absence data 2015-16

NHS Gloucestershire CCG	15/16	14/15
Total days lost	1061	688
Total staff	183	147
Average working days lost	5.80	4.68

Staff sickness absence and ill health retirement in 2015-16

	15/16	14/15
Number of persons retired early on ill health grounds	0	1
Total additional Pensions liabilities accrued in the year	£0	£38,624

External audit

The CCG's external auditors are Grant Thornton UK LLP. The cost of the annual statutory audit of the 2015/16 Financial Statements was £86K. This was determined based upon the size of the CCG's commissioning budget. The CCG did not receive any other services from Grant Thornton in year.

Disabled employees

The CCG has developed an integrated approach to delivering workforce equality so it does not have a separate policy for disabled employees or for any other protected characteristics but it has incorporated equalities issues in policies covering all aspects of employee management ranging from recruitment to performance to discipline.

The CCG's aim is to operate in ways which do not discriminate our potential or current employees with any of protected characteristics specified in the Equality Act 2010 and to support our employees to maximise their performance including making any reasonable adjustments that may be required on a case by case basis.

The CCG publishes their employee profile by each of the nine protected characteristics, this helps the organisation to identify and address areas of under-representation in a systematic manner as and when opportunities arise. On a quarterly basis, the Executive Management Team receives a report on the workforce profile.

More information about the CCG Equality and Diversity strategy can be found on the website: www.gloucestershireccg.nhs.uk/about-us/equality-diversity/reports/

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 member of the governing body in the CCG in the financial year 2015/16 was £140-145k. This was 3.97 (4.01 in 2014/15) times the median remuneration of the workforce which was £35,891. The slight movement in year has been caused by the median salary for the organisation increasing in relation to the Accountable Officer's pay.

In 2015/16, no employees received remuneration in excess of the highest paid member of the governing body. 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.

Off Payroll Engagements

For all off-payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of existing engagements as 31 march 2016	6
of which, the number that have existed:	
- for less than one year at the time of reporting	1
- for between one and two years at the time of reporting	3
- for between two and three years at the time of reporting	2
- for between three and four years at the time of reporting	0
- for four or more years at the time of reporting	0
Total number of existing engagements as of 31 March 2016	6

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	6
Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations	0
Number for whom assurance has been requested	6
Of which, the number:	
- For whom assurance has been received	3
- For whom assurance has not been received	3
- That have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial resonsibility, between 1 April 2015 and 31 March 2016.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board members, and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	21

Staff Report

Senior Manager Remuneration

Senior manager remuneration for the CCG has been set with reference to the guidance "Clinical Commissioning Groups: Remuneration guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officers".

The CCG does not have a policy for performance related pay for its senior managers.

Senior Managers' contracts

The start dates of senior managers who served on the CCG's Governing Body are shown within the remuneration table on page 34.

No special provision for early termination has been detailed in the contracts of individuals and any payments would be limited to those incurred under a standard Agenda For Change contract.

Staff profile

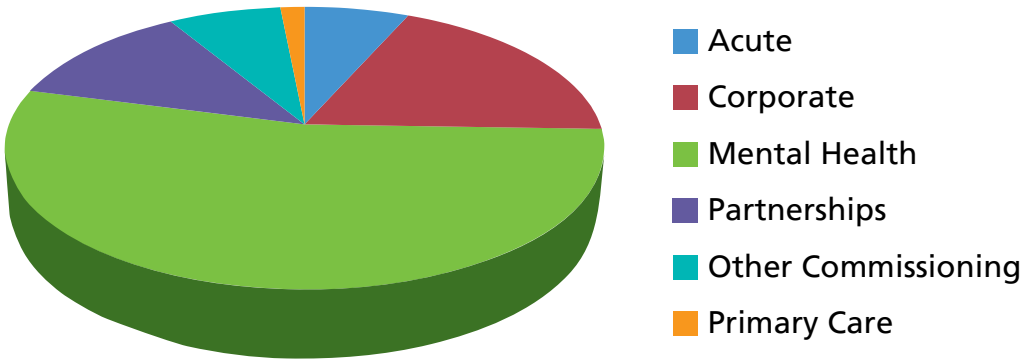
The Profile of staff within the CCG, based on the average number of people employed in 2015/16, is as presented in the table below. This is referred to in note 5.2 of the Annual Accounts.

	Directors	Other employees	Total
Total staff numbers	9	209	218
of which			
- permanent	9	182	191
- other	0	27	27
of which			
Male	4	62	66
Female	5	147	152

- There have been no significant awards made to past senior managers in 2015/16
- There has been no compensation on early retirement or for loss of office in 2015/16
- There have been no payments to past directors in 2015/16
- There have been no exit packages paid in 2015/16.

Consultancy

Consultancy costs of £196k in 2015/16 were spent in the following areas.



Mary Hutton

Accountable Officer

26 May 2016

Statement of Comprehensive Net Expenditure for the year ended 31 March 2016		
	2015-16 £000	2014-15 £000
Total Income and Expenditure		
Employee benefits	9,724	8,109
Operating Expense	814,022	702,131
Other operating revenue	(21,748)	(21,108)
Total Net Expenditure for the year	**801,998**	**689,132**
Of which:		
Administration Income and Expenditure		
Employee benefits	7,800	6,879
Operating Expenses	5,150	6,713
Other operating revenue	(337)	(147)
Net administration costs before interest	**12,613**	**13,445**
Programme Income and Expenditure		
Employee benefits	1,924	1,230
Operating Expenses	808,873	695,418
Other operating revenue	(21,412)	(20,961)
Net programme expenditure before interest	**789,385**	**675,687**
Other Comprehensive Net Expenditure	**0**	**0**
Total comprehensive net expenditure for the year	**801,998**	**689,132**

Statement of Financial Position as at 31 March 2015	31 March 2016	31 March 2015
	£000	£000
Non-current assets:		
Property, plant and equipment	290	188
Total non-current assets	290	188
Current assets:		
Trade and other receivables	7,238	6,150
Cash and cash equivalents	23	104
Total current assets	7,261	6,254
Total assets	7,551	6,442
Current liabilities		
Trade and other payables	(43,221)	(40,361)
Provisions	(1,782)	(863)
Total current liabilities	(45,003)	(41,224)
Total Assets less Current Liabilities	(37,452)	(34,782)
Non-current liabilities	0	0
Total Assets Employed	(37,452)	(34,782)
Financed by Taxpayers' Equity		
General fund	(37,452)	(34,782)
Total taxpayers' equity:	(37,452)	(34,782)

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

Accountable Officer
Mary Hutton

Statement of Changes In Taxpayers Equity for the year ended 31 March 2016	2015-16 General fund	2014-15 General fund
	£000	£000
Changes in taxpayers' equity		
Balance at 1 April	(34,782)	(35,378)
Changes in CCG taxpayers' equity		
Net operating costs for the financial year	(801,998)	(689,132)
Total revaluations against revaluation reserve	0	0
Net Recognised CCG Expenditure for the Financial Year	(836,780)	(724,510)
Net funding	799,328	689,728
Balance at 31 March	(37,452)	(34,782)

Statement of Cash Flows for the year ended	2015-16	2014-15
	£000	£000
Cash Flows from Operating Activities		
Net operating costs for the financial year	(801,998)	(689,132)
Depreciation and amortisation	49	20
(Increase)/decrease in trade & other receivables	(1,088)	2,200
Increase/(decrease) in trade & other payables	2,967	(2,735)
Provisions utilised	(218)	-
Increase/(decrease) in provisions	1,137	(7)
Net Cash Inflow (Outflow) from Operating Activities	(799,151)	(689,654)
Cash Flows from Investing Activities		
(Payments) for property, plant and equipment	(258)	-
Net Cash Inflow (Outflow) from Investing Activities	(258)	-
Net Cash Inflow (Outflow) before Financing	(799,409)	(689,654)
Cash Flows from Financing Activities		
Grant in Aid Funding received	799,328	689,728
Net Cash Inflow (Outflow) from Financing Activities	799,328	689,728
Net Increase (Decrease) in Cash & Cash Equivalents	(81)	74
Cash & Cash Equivalents at the Beginning of the Financial Year	104	30
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	23	104

Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). The clinical commissioning group's performance against those duties was as follows:

	See below	NHS Act 2006 Section	2015-16 Target	2015-16 Performance	Met (Y/N)?	2014-15 Target	2014-15 Performance	Met (Y/N)?
			£000	£000		£000	£000	
Expenditure not to exceed income (i.e. to report surplus)	2.1	223H(1)	833,202	823,746	Yes	718,895	710,387	Yes
Capital resource use does not exceed the amount specified in Directions	2.2	223I(2)	200	151	Yes	161	147	Yes
Revenue resource use does not exceed the amount specified in Directions	2.1	223I(3)	811,454	801,998	Yes	697,626	689,132	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	2.2	223J(1)	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions (e.g. capital grants)	2.3	223J(2)	76,802	75,430	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2.4	223J(3)	14,068	12,613	Yes	15,996	13,445	Yes

	2015-16		2014-15
2.1 Performance against Revenue Resource limit	£000		£000
From Statement of Comprehensive Net Expenditure			
Notified Resource Limit	811,454		697,626
Total Other operating revenue	21,748		21,108
Total Income	833,202		718,734
Employee benefits	9,724		8,109
Operating Costs	814,022		702,131
Total Expenditure	823,746		**710,240**
Under/(Over) spend against Revenue Resource Limit (RRL)	**9,456**		**8,494**

2.2 Performance against Capital Resource limit	2015-16		2014-15
	£000		£000
Capital Expenditure	151		147
Capital Resource Limit	200		161
Under/(Over) spend against Capital Resource Limit (RRL)	**49**		**14**

2.3 Revenue resource use on specified matters

The CCG did not receive any Revenue Resource Limit in 2014/15 for use on specified matters.

2.4 Performance against Revenue administration resource	2015-16	2015-16		2014-15	2014-15
	£000	£000		£000	£000
From Statement of Comprehensive Net Expenditure					
Gross employee benefits	7,800			6,879	
Other costs	5,150			6,713	
Other operating revenue	(337)			(147)	
		12,613			13,445
Revenue administration resource ("running costs" allocation)		14,068			15,996
Under/(Over) spend against Revenue administration resource		1,455			2,551

Statement of the responsibilities of the Accountable Officer of NHS Gloucestershire Clinical Commissioning Group

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 England. NHS England has appointed the Accountable Officer of the Clinical Commissioning Group.

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

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

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

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

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

I also confirm that:

- 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

Mary Hutton

Accountable Officer

26 May 2016

Independent Auditor's Report to the Members of NHS Gloucestershire Clinical Commissioning Group

We have audited the financial statements of NHS Gloucestershire Clinical Commissioning Group for the year ended 31 March 2016 under the Local Audit and Accountability Act 2014 (the "Act"). The financial statements comprise the Statement of Comprehensive Net Expenditure, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the 2015/16 Government Financial Reporting Manual (the 2015/16 FReM) as contained in the Department of Health Group Manual for Accounts 2015/16 (the 2015/16 MfA) and the Accounts Direction issued by the NHS Commissioning Board with the approval of the Secretary of State as relevant to the National Health Service in England (the Accounts Direction).

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

- the table of salaries and allowances of senior managers and related narrative notes on pages 32-33
- the table of pension benefits of senior managers and related narrative notes on pages 34-35
- the tables of pay multiples and related narrative notes on page 32.

This report is made solely to the members of the Governing Body of NHS Gloucestershire Clinical Commissioning Group, as a body, in accordance with Part 5 of the Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by Public Sector Audit Appointments Limited. Our audit work has been undertaken so that we might state to the members of the Governing Body of the CCG those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the CCG and the members of the Governing Body of the CCG, as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities, the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view and is also responsible for ensuring the regularity of expenditure and income. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors. We are also responsible for giving an opinion on the regularity of expenditure and income in accordance with the Code of Audit Practice prepared by the Comptroller and Auditor General as required by the Act (the "Code of Audit Practice").

As explained in the Annual Governance Statement the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the CCG's resources. We are required under Section 21 (1)(c) of the Act to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report our opinion as required by Section 21(4)(b) of the Act.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Accountable Officer; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially

incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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

Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, issued by the Comptroller and Auditor General in November 2015, as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined these criteria as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the CCG had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of NHS Gloucestershire CCG as at 31 March 2016 and of its expenditure and income for the year then ended; and
- have been prepared properly in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction.

Opinion on regularity

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

Opinion on other matters

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the 2015/16 FReM as contained in the 2015/16 MfA and the Accounts Direction; and
- the other information published together with the audited financial statements in the annual report and accounts is consistent with the financial statements.

Matters on which we are required to report by exception

- We are required to report to you if:
- in our opinion the governance statement does not comply with the guidance issued by the NHS Commissioning Board; or
- we refer a matter to the Secretary of State under section 30 of the Act because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Act; or
- we make a written recommendation to the CCG under section 24 of the Act; or

- we are not satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of its resources for the year ended 31 March 2016.

We have nothing to report in these respects.

Certificate

We certify that we have completed the audit of the accounts of NHS Gloucestershire Clinical Commissioning Group in accordance with the requirements of the Act and the Code of Audit Practice.

Elizabeth Cave

for and on behalf of Grant Thornton UK LLP, Appointed Auditor

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

26 May 2016

To discuss receiving this information in large print or Braille please ring **0800 0151 548.**

To discuss receiving this information in other formats please contact:

এই তথ্য অন্য ফর্মাটে পেতে আলোচনার জন্য দয়া করে যোগাযোগ করুন

如需以其他格式接收此信息，请联系

V případě, že potřebujete obdržet tuto informaci v jiném formátu, kontaktujte prosím

આ માહીતી બીજા ફોરમેટસમાં મળાવાની ચર્ચા કરવામાટે કૃપાકરી સંપર્ક કરો

Aby uzyskać te informacje w innych formatach, prosimy o kontakt

По вопросам получения информации в других форматах просим обращаться

Ak si želáte získat túto informáciu v inom formáte, kontaktujte prosím

FREEPOST RRYY-KSGT-AGBR,
PALS, NHS Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park Gloucester GL3 4FE

www.twitter.com/GlosCCG
www.facebook.com/GlosCCG
www.gloucestershireccg.nhs.uk

Data entered below will be used throughout the workbook:

Entity name:	NHS Gloucestershire CCG
This year	2015-16
This year ended	31-March-2016
This year commencing:	01-April-2015

These account templates are a proforma for a set of NHS England Group Entity Accounts, this is not a mandatory layout for local accounts.

Please review and adjust to local reporting requirements

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2015-16 £000	2014-15 £000
Total Income and Expenditure			
Employee benefits	5.1.1	9,724	8,109
Operating Expenses	6	814,022	702,131
Other operating revenue	3	(21,748)	(21,108)
Total Net Expenditure for the year		**801,998**	**689,132**
Of which:			
Administration Income and Expenditure			
Employee benefits	5.1.1	7,800	6,879
Operating Expenses	6	5,150	6,713
Other operating revenue	3	(337)	(147)
Net administration costs before interest		**12,613**	**13,445**
Programme Income and Expenditure			
Employee benefits	5.1.1	1,924	1,230
Operating Expenses	6	808,873	695,418
Other operating revenue	3	(21,412)	(20,961)
Net programme expenditure before interest		**789,385**	**675,687**
Other Comprehensive Net Expenditure		**0**	0
Total comprehensive net expenditure for the year		**801,998**	**689,132**

The notes on pages 5 to 22 form part of this statement

Statement of Financial Position as at 31-March-2016

	Note	2015-16 £000	2014-15 £000
Non-current assets:			
Property, plant and equipment	9	290	188
Total non-current assets		290	188
Current assets:			
Trade and other receivables	10	7,238	6,150
Cash and cash equivalents	11	23	104
Total current assets		7,261	6,254
Total assets		7,551	6,442
Current liabilities			
Trade and other payables	12	(43,221)	(40,361)
Provisions	13	(1,782)	(863)
Total current liabilities		(45,003)	(41,224)
Non-Current Assets plus/less Net Current Assets/Liabilities		(37,452)	(34,782)
Non-current liabilities		0	0
Assets less Liabilities		(37,452)	(34,782)
Financed by Taxpayers' Equity			
General fund		(37,452)	(34,782)
Total taxpayers' equity:		(37,452)	(34,782)

The notes on pages 5 to 22 form part of this statement

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

Accountable Officer
Mary Hutton

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

	2015-16	2014-15
	General fund £000	General fund £000
Changes in taxpayers' equity		
Balance at 1 April	(34,782)	(35,378)
Changes in NHS Clinical Commissioning Group taxpayers' equity		
Net operating expenditure for the financial year	(801,998)	(689,132)
Total revaluations against revaluation reserve	**0**	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(836,780)**	(724,510)
Net funding	799,328	689,728
Balance at 31 March	**(37,452)**	(34,782)

The notes on pages 5 to 22 form part of this statement

The General Fund is the only reserve for NHS Gloucestershire CCG

Statement of Cash Flows for the year ended 31-March-2016

	Note	2015-16 £000	2014-15 £000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(801,998)	(689,132)
Depreciation and amortisation	6	49	20
Unwinding of Discounts		0	0
(Increase)/decrease in trade & other receivables	10	(1,088)	2,200
Increase/(decrease) in trade & other payables	12	2,967	(2,735)
Provisions utilised	13	(218)	0
Increase/(decrease) in provisions	13	1,137	(7)
Net Cash Inflow (Outflow) from Operating Activities		**(799,151)**	(689,654)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(258)	0
Net Cash Inflow (Outflow) from Investing Activities		**(258)**	0
Net Cash Inflow (Outflow) before Financing		**(799,409)**	(689,654)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		799,328	689,728
Net Cash Inflow (Outflow) from Financing Activities		**799,328**	689,728
Net Increase (Decrease) in Cash & Cash Equivalents	11	**(81)**	74
Cash & Cash Equivalents at the Beginning of the Financial Year		**104**	30
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**23**	**104**

The notes on pages 5 to 22 form part of this statement

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2015-16* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Pooled Budgets

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

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

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

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

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

1.4 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.4.1 Critical Judgements in Applying Accounting Policies

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

• Lead Commissioning arrangements
Where the CCG is the lead commissioner for service level agreements that include a contribution from Gloucestershire County Council, all figures are shown in gross terms (i.e. the contribution from the local authority is shown within Other Operating Income).

• Better Care Fund
The Better Care Fund (BCF) has been accounted for as an aligned pool in line with other Joint Commissioning Arrangements with the Council.

Notes to the financial statements

1.4.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

• Partially Completed Spells
Estimates of expenditure relating to such spells have primarily been taken from analysis provided by secondary care providers.

• Accruals for delegated co-commisioning of primary care services
Actual core spend on primary care services relating to Quality and Outcomes Framework (QOF) and national enhanced services are issued in arrears and, therefore, the annual estimate is based on forecast information derived from National primary care monitoring database and historical trends.

• Accruals for Prescribing/Home Oxygen costs
Primary care prescribing information is received from the Business Services Authority who process prescription items to reimburse and remunerate pharmacy contractors and provide information on the cost of drugs prescribed by primary care prescribers. Actual prescribing information is issued in arrears and, therefore, the annual estimate is based on forecast information issued by the NHS Business Services Authority.

• Provisions recognised as at 31st March 2016
The provision for continuing healthcare has been calculated by taking those claims outstanding at 31 March 2016 which had not previously been notified to NHS England. An assessment of the estimated/potential financial value is then made and a likelihood factor applied (based on previous experience).

• Secondary Healthcare service costs
Secondary Healthcare activity information is collected on a national system "Secondary Users System" (SUS). This data is subsequently imported into a local contract management system. Secondary Healthcare providers are paid in year for activity which has been carried out and which is due under the contract terms. However, the final year end activity for which the CCG will be charged will not be available until June, therefore estimates of the activity has been provided based on the information from the contract monitoring system and providers themselves. The estimated creditor for the final month of the year is included within Trade and Other Payables.

1.5 Revenue

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

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

1.6 Employee Benefits

1.6.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.6.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.
For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment.

1.7 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.
Expenses and liabilities in respect of grants are recognised when the clinical commissioning group has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

Notes to the financial statements

1.8 Property, Plant & Equipment

1.8.1 Recognition

Property, plant and equipment is capitalised if:

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

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.8.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from current value in existing use.

1.8.3 Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.9 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.

1.9.1 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.

1.10 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.

1.11 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.55% (2014-15: minus 1.50%)
- Timing of cash flows (6 to 10 years inclusive): Minus 1% (2014-15: minus 1.05%)
- Timing of cash flows (over 10 years): Minus 0.80% (2014-15: plus 2.20%)

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

1.12 Clinical Negligence Costs

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

Notes to the financial statements

1.13 Non-clinical Risk Pooling

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

1.14 Continuing healthcare risk pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning group contribute annually to a pooled fund, which is used to settle the claims. This scheme continued in 2015/16.

1.15 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.
A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.
Where the time value of money is material, contingencies are disclosed at their present value.

1.16 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:

- Loans and receivables.

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

1.16.1 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.
At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.
For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

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

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.
Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.17.1 Financial Guarantee Contract Liabilities

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

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

Notes to the financial statements

1.17.2 Financial Liabilities at Fair Value Through Profit and Loss

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

1.17.3 Other Financial Liabilities

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

1.18 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.

1.19 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.20 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).

1.21 Joint Operations

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

1.22 Research & Development

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

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

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

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

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

1.24 Better Care Fund

The Better Care Fund (BCF) is a joint arrangement with the Gloucestershire County Council and has been classified as an aligned pooled budget for accounting purposes.

During 2015/16 the BCF was constituted of 37 separate schemes of which
- Gloucestershire CCG took the commissioning lead on 24 schemes
- Gloucestershire County Council took the commissioning lead on 12 schemes (one of which relied on a shared funding contribution from the CCG)

- One scheme (Reablement in Ashley House and the Kingham Unit) was jointly commissioned and has been deemed to be under the joint control of both organisations. The risks and rewards are shared on an equal basis and is not material financially. In 2015/16 the CCG reported costs of £534k of a total service cost of £1,068k; representing 2.7% of the total BCF planned spend of £39,946k.

2 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:

	See below	NHS Act 2006 Section	2015-16 Target	2015-16 Performance	Met (Y/N)?	2014-15 Target	2014-15 Performance	Met (Y/N)?
Expenditure not to exceed income	2.1	223H (1)	833,202	823,746	Yes	718,895	710,387	Yes
Capital resource use does not exceed the amount specified in Directions	2.2	223I (2)	200	151	Yes	161	147	Yes
Revenue resource use does not exceed the amount specified in Directions	2.1	223I (3)	811,454	801,998	Yes	697,626	689,132	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	2.2	223J (1)	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	2.3	223J (2)	76,802	75,430	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2.4	223J (3)	14,068	12,613	Yes	15,996	13,445	Yes
					Yes			

2.1/2.2 Performance against Resource limit

	2015-16 £000 Revenue	2015-16 £000 Capital	2015-16 £000 Total	2014-15 £000 Revenue	2014-15 £000 Capital	2014-15 £000 Total
From Statement of Comprehensive Net Expenditure (page 1)						
Notified Resource Limit	811,454	200	811,654	697,626	161	697,787
Total Other operating revenue	21,748		21,748	21,108		21,108
Total Income	833,202	200	833,402	718,734	161	718,895
Employee benefits	9,724		9,724	8,109		8,109
Operating costs	814,022	151	814,174	702,131	147	702,278
Total Expenditure	823,746	151	823,898	710,240	147	710,387
Under/(Over) spend	9,456	49	9,505	8,494	14	8,508

2.3 Revenue resource use on specified matters

This relates to delegated co-commissioning of primary care services and reports the initial indicative allocation as at 1 April 2015. During the year rebasing adjustments reduced this by £1,362k to a total of £75,440k. The CCG has reported an outturn underspend of £10k against this revised baseline.

2.4 Performance against Revenue administration resource

	2015-16 £000	2015-16 £000	2014-15 £000	2014-15 £000
From Statement of Comprehensive Net Expenditure (page 1)				
Gross employee benefits	7,800		6,879	
Other costs	5,150		6,713	
Other operating revenue	(337)		(147)	
		12,613		13,445
Revenue administration resource ("running costs" allocation)		14,068		15,996
Under/(Over) spend against Revenue administration resource		1,455		2,551

3 Other Operating Revenue

	2015-16 Total	2015-16 Admin	2015-16 Programme	2014-15 Total
	£000	£000	£000	£000
Charitable and other contributions to revenue expenditure: non-NHS	262	152	110	58
Non-patient care services to other bodies	20,805	114	20,691	20,391
Other revenue	681	71	610	659
Total other operating revenue	**21,748**	**337**	**21,412**	**21,108**

Administrative revenue is revenue received that is not directly attributable to commissioning of healthcare services.

Non-patient care services to other bodies primarily relates to charges made to Gloucestershire County Council for their contribution to contracts where the lead commissioner is NHS Gloucestershire CCG

Revenue in this note does not include cash received from NHS England which is drawn down directly into the bank

4 Revenue

Revenue is totally from the supply of services. No revenue is received from the sale of goods.

5. Employee benefits and staff numbers

5.1.1 Employee benefits

2015-16	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	8,154	7,333	821	6,505	5,941	565	1,648	1,392	256
Social security costs	614	614	0	513	513	0	101	101	0
Employer Contributions to NHS Pension scheme	956	956	0	782	782	0	174	174	0
Gross employee benefits expenditure	**9,724**	**8,903**	**821**	**7,800**	**7,235**	**565**	**1,924**	**1,668**	**256**

5.1.1 Employee benefits

2014-15	Total			Admin			Programme		
	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000	Total £000	Permanent Employees £000	Other £000
Employee Benefits									
Salaries and wages	6,778	6,315	464	5,742	5,349	393	1,036	966	70
Social security costs	532	532	0	461	461	0	71	71	0
Employer Contributions to NHS Pension scheme	799	799	0	676	676	0	123	123	0
Gross employee benefits expenditure	**8,109**	**7,646**	**464**	**6,879**	**6,486**	**393**	**1,230**	**1,160**	**70**

5.1.2 Recoveries in respect of employee benefits

There were no recoveries in respect of employee benefits in 2015/16 (2014/15: Nil)

5.2 Average number of people employed

	2015-16			2014-15
	Total Number	Permanently employed Number	Other Number	Total Number
Total	**218**	**191**	**27**	178
Of the above:				
Number of whole time equivalent people engaged on capital projects	**0**	**0**	**0**	0

5.3 Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	1061	688
Total Staff Years	183	147
Average working Days Lost	**5.80**	**4.68**

	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	0	1
	£000	**£000**
Total additional Pensions liabilities accrued in the year	0	39

Ill health retirement costs are met by the NHS Pension Scheme

5.4 Pension costs

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

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

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

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

5.4.1 Full actuarial (funding) valuation

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

For 2015-16, employers' contributions of £956k were payable to the NHS Pensions Scheme (2014-15: £799k) were payable to the NHS Pension Scheme at the rate of 14.3% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. The latest review used data from 31 March 2012 and was published on the Government website on 9th June 2014.

6. Operating expenses

	2015-16 Total £000	2015-16 Admin £000	2015-16 Programme £000	2014-15 Total £000
Gross employee benefits				
Employee benefits excluding governing body members	8,938	7,014	1,924	7,419
Executive governing body members	786	786	0	690
Total gross employee benefits	**9,724**	**7,800**	**1,924**	**8,109**
Other costs				
Services from other CCGs and NHS England	4,011	2,030	1,981	4,824
Services from foundation trusts	426,764	0	426,764	413,240
Services from other NHS trusts	105,428	95	105,333	103,912
Purchase of healthcare from non-NHS bodies	83,609	0	83,609	70,946
Chair and Non Executive Members	673	658	15	655
Supplies and services – clinical	2,040	0	2,040	1,887
Supplies and services – general	2,518	120	2,398	1,794
Consultancy services	196	37	159	209
Establishment	1,325	399	926	959
Transport	34	34	0	37
Premises	1,170	1,178	(8)	1,294
Impairments and reversals of receivables	(31)	(31)	0	22
Depreciation	49	49	0	21
Audit fees	86	86	0	114
Other non statutory audit expenditure · Other services	1	1	0	1
Prescribing costs	94,968	0	94,968	89,755
General ophthalmic services	68	0	68	13
GPMS/APMS and PCTMS - Locally Enhanced Services	7,802	0	7,802	6,717
Co-commissioning of GP primary care services under delegated arrangements *	75,430	0	75,430	0
Other professional fees excl. audit	999	306	693	780
Grants to other public bodies	4,286	0	4,286	3,726
Clinical negligence	0	0	0	0
Research and development (excluding staff costs)	36	23	12	21
Education and training	235	164	72	184
Change in discount rate	0	0	0	0
Provisions	1,137	0	1,137	(7)
CHC Risk Pool contributions	1,154	0	1,154	980
Other expenditure	34	0	34	47
Total other costs	**814,022**	**5,150**	**808,872**	**702,131**
Total operating expenses	**823,746**	**12,950**	**810,796**	**710,240**

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

* From 01 April 2015, Gloucestershire CCG had delegated responsibility from NHS England for the commissioning of primary care services

7 Better Payment Practice Code

Measure of compliance	2015-16 Number	2015-16 £000	2014-15 Number	2014-15 £000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	7,791	49,241	6,674	51,658
Total Non-NHS Trade invoices paid within target	7,557	47,919	6,422	51,111
Percentage of Non-NHS Trade invoices paid within target	**97.00%**	**97.32%**	**96.22%**	**98.94%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,578	484,156	3,653	411,744
Total NHS Trade Invoices Paid within target	3,526	482,773	3,610	411,506
Percentage of NHS Trade invoices paid within target	**98.55%**	**99.71%**	**98.82%**	**99.94%**

8. Operating Leases

8.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Ltd. For 2015/16 and 2014/15, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 8.1.1.

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

Other lease costs relate to photocopiers.

Under delegated co-commissioning of primary care services arrangements, NHS Gloucestershire CCG has entered into certain financial arrangements involving the use of GP premises. These have been considered under:
IAS 17 Leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease.
The CCG has determined that these are operating leases that must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in operating expenses is £5.4m

Independent Sector Treatment Centres were opened in November 2009 at Emerson's Green, South Gloucestershire and at Cirencester Hospital, Gloucestershire. There was a service agreement between UKSH, the service provider, and the Department of Health to provide an agreed range of treatments until the contract ceased on 31st October 2015. This activity was provided to and purchased by NHS Gloucestershire and CCGs adjacent to the area. An assessment of the contract against IFRIC 12, IFRIC 4 and IAS 17 has determined that an operating lease existed. The price within the service contract used the NHS tariff for secondary care. The service payment to UKSH in 2015/16 was £3,704k. (2014/15: £6,927k)

8.1.1 Payments recognised as an Expense

	2015-16			2014-15		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payments recognised as an expense						
Minimum lease payments	1,023	7	**1,030**	1,250	3	**1,253**
Contingent rents	0	0	**0**	0	0	**0**
Sub-lease payments	0	0	**0**	0	0	**0**
Total	**1,023**	**7**	**1,030**	**1,250**	**3**	**1,253**

Whilst our arrangements with Community Health Partnership's Limited and 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

8.1.2 Future minimum lease payments

	2015-16			2014-15		
	Buildings £000	Other £000	Total £000	Buildings £000	Other £000	Total £000
Payable:						
No later than one year	0	0	**0**	-	-	**0**
Between one and five years	0	0	**0**	-	5	**5**
After five years	0	0	**0**	-	-	**0**
Total	**0**	**0**	**0**	**0**	**5**	**5**

9 Property, plant and equipment

	2015-16			2014-15		
2015-16	**Transport equipment £000**	**Information technology £000**	**Total £000**	Transport equipment £000	Information technology £000	Total £000
Cost or valuation at 01 April	81	652	733	81	505	586
Additions purchased	0	151	151	0	147	147
Cost/Valuation At 31 March	**81**	**803**	**884**	**81**	**652**	**733**
Depreciation 01 April	41	505	545	20	505	525
Charged during the year	20	29	49	21	0	21
Depreciation at 31 March	**61**	**534**	**594**	**41**	**505**	**546**
Net Book Value at 31 March	**20**	**270**	**290**	**40**	**147**	**187**
Purchased	20	270	290	41	147	188
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March	**20**	**270**	**290**	**41**	**147**	**188**
Asset financing:						
Owned	20	270	290	41	147	188
Total at 31 March	**20**	**270**	**290**	**41**	**147**	**188**

9.1 Cost or valuation of fully depreciated assets

The cost or valuation of fully depreciated assets still in use was as follows:

	2015-16 £000	2014-15 £000
Information technology	505	505
Total	**505**	**505**

9.2 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Transport equipment	2	2
Information technology	4	5

10 Trade and other receivables	Current 2015-16 £000	Current 2014-15 £000
NHS receivables: Revenue	420	901
NHS prepayments	18	147
NHS accrued income	170	0
Non-NHS receivables: Revenue	837	2,509
Non-NHS prepayments	723	2,379
Non-NHS accrued income	4,919	0
Provision for the impairment of receivables	(52)	(83)
VAT	180	280
Other receivables	23	17
Total Trade & other receivables	**7,238**	**6,150**

The great majority of trade is with NHS organisations and Gloucestershire County Council. As NHS organisations are funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary. A similar approach has been taken with Gloucestershire County Council.

10.1 Receivables past their due date but not impaired	2015-16 £000	2014-15 £000
By up to three months	456	1,161
By three to six months	1	8
By more than six months	49	0
Total	**506**	**1,169**

£283k of the amount above has subsequently been recovered post the statement of financial position date.

The CCG did not hold any collateral against receivables outstanding at 31 March 2016. (2014/15: Nil)

10.2 Provision for impairment of receivables	2015-16 £000	2014-15 £000
Balance at 01-April-2015	(83)	(61)
Amounts recovered during the year	0	21
(Increase) decrease in receivables impaired	31	(43)
Balance at 31-March-2016	**(52)**	**(83)**

10.3 Non-current: capital analysis

	2015-16 £000	2014-15 £000
Capital revenue	200	161
Capital expenditure	(151)	(147)

11 Cash and cash equivalents

	2015-16 £000	2014-15 £000
Balance at 01-April-2015	104	30
Net change in year	(81)	74
Balance at 31-March-2016	**23**	**104**
Made up of:		
Cash with the Government Banking Service	23	104
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**23**	**104**
Total bank overdrafts	**0**	**0**
Balance at 31-March-2016	**23**	**104**
Patients' money held by the clinical commissioning group, not included above	0	0

12 Trade and other payables	**Current 2015-16 £000**	Current 2014-15 £000
NHS payables: revenue	7,368	9,748
NHS accruals	6,093	4,768
Non-NHS payables: revenue	5,161	1,632
Non-NHS payables: capital	40	147
Non-NHS accruals	23,977	23,294
Social security costs	109	93
Tax	108	95
Other payables	366	584
Total Trade & Other Payables	**43,221**	**40,361**

Other payables include £165k outstanding pension contributions at 31 March 2016 (£142k at 31st March 2015)

13 Provisions

	Current 2015-16 £000	Non-current 2015-16 £000	Current 2014-15 £000	Non-current 2014-15 £000
Continuing care	1,282	0	682	0
Other	500	0	181	0
Total	**1,782**	**0**	**863**	**0**
Total current and non-current	**1,782**		**863**	

	2015-16			2014-15		
	Continuing Care £000s	Other £000s	Total £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 01 April	**682**	**181**	**863**	**870**	**0**	**870**
Arising during the year	1,039	320	1,359	586	181	767
Utilised during the year	(217)	(1)	(218)	0	0	0
Reversed unused	(222)	0	(222)	(774)	0	(774)
Unwinding of discount	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0
Transfer (to) from other public sector body	0	0	0	0	0	0
Balance at 31 March	**1,282**	**500**	**1,782**	**682**	**181**	**863**
Expected timing of cash flows:						
Within one year	1,282	500	1,782	682	181	863
Between one and five years	0	0	0	0	0	0
After five years	0	0	0	0	0	0
Balance at 31-March	**1,282**	**500**	**1,782**	**682**	**181**	**863**

The continuing care provision of £1,282k (2014-15: £682k is for costs expected to be incurred in relation to backdated claims received by the CCG since 1st April 2013 for continuing healthcare and which have yet to be assessed. Claims are assessed for eligibility using the national guidance and toolkit.
NHS England hold a provision for all backdated claims received prior to 1 April 2013

The claims outstanding at 31 March 2016 will be assessed and are expected to be paid within the 2016/17 financial year

Provisions made under the 'Other' category relates to potential primary care costs regarding paractice development and other issues

14 Financial instruments

14.1 Financial assets

	Loans and Receivables 2015-16 £000	Loans and Receivables 2014-15 £000
Receivables:		
· NHS	590	901
· Non-NHS	5,756	2,509
Cash at bank and in hand	24	104
Other financial assets	23	17
Total at 31-March-2016	**6,393**	**3,531**

14.2 Financial liabilities

	Other 2015-16 £000	Other 2014-15 £000
Payables:		
· NHS	13,461	14,516
· Non-NHS	29,544	25,656
Total at 31-March-2016	**43,005**	**40,172**

15 Operating Segments

The CCG and consolidated group consider that they have only one segment: commissioning of healthcare services
NHS Gloucestershire CCG presents its regular reports to the Governing Body (designated as the organisations Chief Operating Decision Maker) in this format

16 Pooled budgets

The pooled budget relates to integrated community equipment services with Gloucestershire County Council

This service has been running for a number of years and buys, delivers, collects, maintains and decontaminates equipment for patients in their own homes. This service is jointly commissionedby the CCG, with Gloucestershire County Council, who are the lead commissioner for the service.

The NHS Clinical Commissioning Group share of the income and expenditure handled by the pooled budget in the financial year are:

	2015-16 £000	2014-15 £000
Income	3,358	3,664
Expenditure	(3,358)	(3,664)

17 Related party transactions

During the year, with the exception of those listed below, none of the Department of Health Ministers, clinical commissioning group Governing Body members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with the clinical commissioning group.

	2015/16 Payments to Related Party				2014/15 Payments to Related Party		
	Payments under delegated co-commissioning arrangements	Drugs reimbursed	Other payments	Total Payments	Drugs reimbursed	Other payments	Total Payments
	£000	£000	£000	£000	£000	£000	£000
Dr Helen Miller (Clinical Chair of CCG) *Partner - The College Yard and Highnam Surgery*	639	341	61	1041	331	33	364
Dr Caroline Bennett (CCG Member/GP Locality Lead) *Partner - Cotswold Medical Practice*	1394	595	155	2144	546	102	648
Dr Charles Buckley (CCG Member/GP Locality Lead) *Partner - Frampton Surgery*	602	384	57	1043	351	56	407
Dr Malcolm Gerald (CCG Member/GP Locality Lead) *Partner - Romney House Surgery*	833	161	98	1092	160	98	258
Dr Martin Gibbs (CCG Member/GP Locality Lead) *Partner - Blakeney Surgery*	501	345	37	883	349	26	375
Dr Sadaf Haque (GP Locality Lead from 01/06/15) *GP Locum*		0	0	0	0	0	0
Dr William Haynes (CCG Member/GP Locality Lead) *Partner - Hadwen Medical Practice*	1683	71	274	2028	80	218	298
Dr Tristan Lench (CCG Member/GP Locality Lead from 09/04/15) *Partner - Severnbank Surgery*	564	155	48	767	0	0	0
Dr Hein Le Roux (CCG Member/GP Locality Lead) *Minchinhampton Surgery*	844	53	88	985	54	71	125
Dr Andrew Seymour (CCG Deputy Clinical Chair) *Partner - Heathville Road Surgery*	1641	53	114	1808	51	98	149
Dr Jeremy Welch (CCG Member/GP Locality Lead) *Partner - Jesmond House Surgery*	1267	62	131	1460	22	47	69
Jonathan Jeanes (Interim Dir of Transformation/Service Redesign to 31/03/15) *MD of Jeanes Consulting Ltd*	0	0	0	0	0	20	20
Dr Raju Reddy (Secondary Care Doctor Advisor to CCG from 01/11/15) *Birmingham Childrens Hospital NHS Foundation Trust*	*0*	*0*	*34*	34	*0*	*0*	0
Dr Steven Allder (Secondary Care Doctor Advisor to CCG to 31/03/15) *Consultant Neurologist (Plymouth Hospitals NHS FT)/Consultant for Kings Fund*	0	0	0	0	0	24	24

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

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 Gloucestershire County Council in respect of joint commissioning of services.

The clinical commissioning group has also received revenue and capital payments from a number of charitable funds.

Payments to primary care contractors, under devolved commissioning arrangements, are governed by the Primary Care Commissioning Committee (PCCC) which is a formal sub-committee of the Governing Body.

18 Events after the end of the reporting period

Devolution

A bid has been submitted to government to support greater devolution of services in Gloucestershire. "We are Gloucestershire" has been developed by countywide partners including

- Gloucestershire County Council
- Six district councils
- GFirst Local Enterprise Partnership (LEP)
- Police and Crime Commissioner (PCC)
- Gloucestershire CCG

Sustainability and Transformation Plans (STP)

The recent NHS planning guidance asked every health and care system to come together to create their own ambitious blueprint for accelerating implementation of the Five Year Forward View, through the production of a Sustainability and Transformation Plan (STP). The STP will be a place-based, multi-year plan built around the needs of the local population. The Gloucestershire STP footprint includes the following organisations

- Gloucestershire CCG
- Gloucestershire Hospitals NHS Foundation Trust
- 2Gether NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- Gloucestershire County Council
- South Western Ambulance Services NHS Foundation Trust

The initial plan will be submitted by the end of June 2016.