Annual Review

NHS
Gloucestershire
Clinical Commissioning Group

Healthy Living Pharmacies
– set to arrive in a community near you

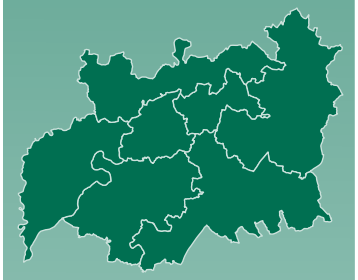
Trusts pool their talents to boost Respiratory Services

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

2013 – 2014

Annual Report 2013-14

A message from:



> “Great work going on to improve health and care”

This is the first Annual Report for NHS Gloucestershire Clinical Commissioning Group and there is much to tell you about.

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

During our ‘Joining up your Care (JUYC)’ discussions with the public earlier this year, there was a clear view that the work we are doing across the NHS (set out in the pages that follow) can help to tackle issues such as an ageing population, more people living with more complex, long term illness and the limited amounts of money available.

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.

None of this could be achieved without the dedication and hard work of our member practices and staff working across Gloucestershire.

This Report highlights some of the things we are doing, but we acknowledge that much more needs to be done if we are to put the NHS and social care on a sound footing for the future and meet the health needs of you and your family in the years to come.

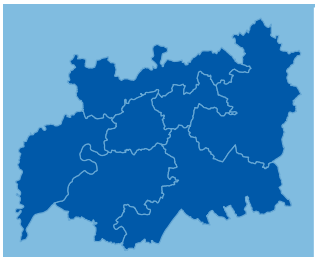
As we develop our plans, we will continue to use the feedback we have received as part of JUYC and individual feedback from you as patients, carers and members of the public to guide our decision making.

We wish you the best of health.

Dr Helen Miller
Clinical Chair

Mary Hutton
Accountable Officer

Member Practices' Introduction



> "working hard with community partners to identify local health needs"

This has been a positive, but demanding first year for the CCG and its members.

Good progress has been made in planning care, services and support that will help the organisation and wider health community tackle the challenges of the future.

The CCG Governing Body and the CCG GP locality executives have worked closely with public health and other community partners to identify local health needs and develop plans that help to address them.

A number of new initiatives have, or are being, introduced by the CCG and its member GP practices to provide a wider range of services for patients at a 'local' level. This includes our 'Primary Care Offer' as well as:

- More proactive and planned support to Care Homes
- A wider range of care for patients with diabetes, following a comprehensive GP education programme
- Care for patients with suspected deep vein thrombosis (DVT) at their local GP surgery, avoiding travel to hospital
- Early cancer diagnosis – significant investment in GP education is being made to ensure patients have better health outcomes, this includes sharing best practice
- GPs working with other health and social care professionals to support patients who are reaching the end of their lives, understanding their needs and developing their care plans
- Developing a number of pilots with community providers, so patients can be referred by their GP to services that meet their wider needs e.g. carer support, housing and benefits, social inclusion and transport. This approach will be further developed in 2014.

Member GP practices have also worked hard with CCG commissioning lead GPs and managers to carefully review referrals to other services for the benefit of patients and the NHS and work continues to ensure high quality, cost effective and safe prescribing of medicines.

A self-assessment of the organisation, including an analysis of the performance of the Governing Body, was undertaken in December 2013.

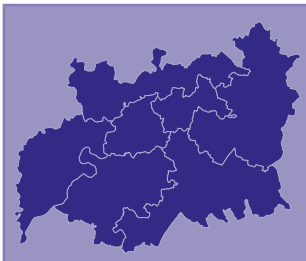
This review considered the degree of compliance with the Draft Framework of Excellence in Clinical Commissioning, published by NHS England. The conclusion of this review was that there was a good level of compliance with the Framework principles and that the organisation was generally operating well.

A small number of areas were identified where performance could be improved and an action plan to address these was produced and included in the CCG's work programme.

Through an agreed joint vision and strong commissioning plans, we are confident that the CCG Governing Body, member GP practices and our community partners are well placed to make further progress in care, treatment and support for our patients and communities.

CCG Commissioning lead GPs

Across the county



Advice to support care close to home

“it was helpful to get an expert’s opinion so quickly”

Patients in Gloucestershire are now receiving expert medical help more quickly thanks to the advice and guidance service for GPs.

GPs can now get a second opinion on a person’s condition from a hospital doctor by sending a secure electronic advice request message.

The message may include things like scanned images and results of tests. The hospital doctor responds within three days with proposed treatment plans or links to other information.

It means patients can often be treated by doctors in their local GP surgery, avoiding the need for a hospital visit.

Advice and guidance services are in place for children and for people with diabetes, skin conditions, kidney conditions, ear nose and throat problems and rheumatology.

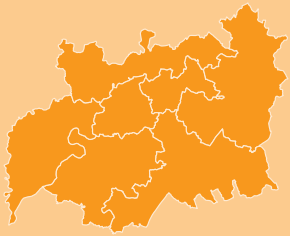
Your experience

“I was a bit concerned about a strange rash on my daughter’s arm and although it wasn’t itchy or inflamed, I took her to our GP.

The cream he prescribed didn’t help, so he took a photograph and sent it to a dermatologist at the hospital. The dermatologist got back to him the next day, and said it was a rare form of eczema that usually resolves itself.

It was really helpful to get an expert’s opinion so quickly and not have the hassle of making hospital appointments.”

Rachel from Newent



More choice on where you get your tests

The NHS is giving patients a greater choice of where and when they receive tests to work out what condition or illness they have.

Patients can now have more tests, such as endoscopy, ultrasound, CT and MRI scans at community hospitals and other places in their local community.

Once the person has been referred by their doctor, they will get pre-test information and then the test is carried out at a time and place of their choosing.

The doctor will discuss the findings with the patient and if the condition can be managed in the GP surgery then this can speed up treatment further.

"the appointment was made very quickly"

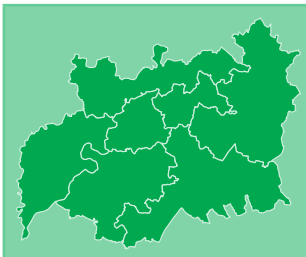
Your experience

"I found this to be a friendly, local service, and the appointment was made very quickly.

I was taken to my appointment and was immediately put at ease by the staff in the ultrasound clinic. They explained the procedure clearly and carried it out with no sense of rushing me, and I had an overall feeling of real care and understanding.

My dignity was a priority, and I knew exactly what was happening, so felt happy throughout the whole procedure."

Paul from Stow-on-the-Wold



Health and social care join up their community teams

With a £3.9 million cash boost we are developing joined up (integrated) community teams in Gloucestershire giving people access to 24 hour a day, 7 day a week support where they live.

The teams include GPs and a range of other professionals in social care, nursing and therapy services.

They provide a fast response when needed (within 1 hour), a high intensity service, where people get extra care for a short time to help them recover, and routine care.

The teams support people if they have a long term health condition like diabetes, heart conditions and lung disease providing high quality care at home, rather than in hospital.

It's also helping to reduce the time people need to spend in hospital with joined up care after they leave.

"they really made me feel better"

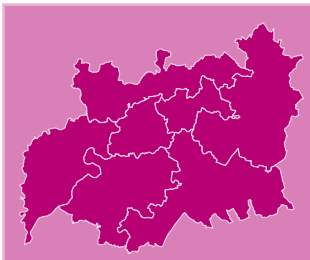
Your experience

"I remember how efficient they were. Within seconds they were doing blood pressure checks and talking to me. They were so kind. They really made me feel better instantaneously. If you get somebody who knows the job, and who can talk to you properly, they make everything so easy.

They certainly didn't push me to go to hospital. In hospital I've always been treated well, but I was treated just as well, if not better, here at home.

The first day they came three times and we both knew jolly well that if we did have to ring, they would come. We had different members of the team, and everyone was the same. They were so good, so polite, so helpful."

Mr Keene from Longford



A more proactive approach to Care home support

People living in care homes in Gloucestershire should now be receiving more planned and proactive support from GPs.

Doctors are now carrying out regular visits, assessing medical needs, reviewing medicines and reviewing the reason for hospital visits.

This is bringing benefits to the individual and means people are less likely to have to go to hospital lots of times.

This initiative has also strengthened working relationships between GP surgeries and care homes.

"it's more efficient and easier to get a diagnosis"

Your experience

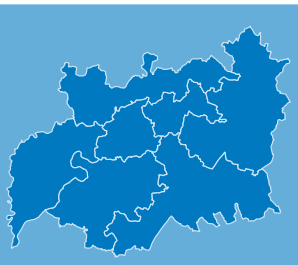
"As the GP has a good working knowledge of the resident's current needs, their past medical history and family matters, it's more efficient now and it's easier to get a diagnosis.

Medication reviews are carried out more regularly which means that current medication is always relevant to the health needs of residents.

The system is more efficient as our nurses know when the GP is coming to the home. This means that they get the appropriate information and residents ready to be seen, so the GP doesn't have to wait for staff and equipment to be found to move the resident into a wheelchair or room.

Calls to Out of Hours services have decreased, as have visits to hospital. This is due mainly to the fact that the GP visits at least fortnightly to review the residents, so non urgent consultations can be planned."

Suzanne Dutch, Manager at Charnwood House Nursing Home, Gloucester



Tackling the dementia challenge

People with dementia in Gloucestershire are now more likely to be diagnosed early.

Diagnosis rates are improving according to a clinical study which every GP surgery took part in.

Rates have risen from 36% to over 53% over the past two years. Based on the size of our population, there should be around 8,260 people with dementia. There are currently over 4,400 patients with a diagnosis.

Early diagnosis can make a huge difference in helping people stay independent for longer, giving the individual and their family the best chance to prepare, plan and receive any treatment.

In Gloucestershire there is also a range of support available.

This includes a memory assessment service, education programmes for carers and health care workers, dementia advisors who provide information on services and support, community dementia nurses and memory cafes where people can meet.

"it's reassuring to know she will be there to help me"

Your experience

"It's really hard looking after Mum. It feels like she's not there anymore. Some days are so difficult that I almost wish she wasn't, which makes me feel really guilty.

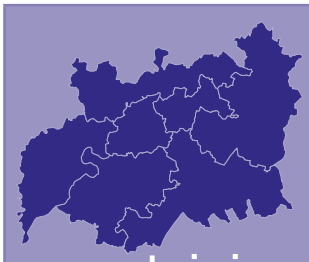
Mum's Community Dementia Nurse saw that I was struggling to cope and referred me to a Dementia Advisor, Katie, who visited me at home two days later. I explained how overwhelming things felt. She was really understanding and came up with some suggestions which have made a world of difference.

I've now talked things through with a counsellor and Katie also put me in touch with a dietician so that I can ensure Mum gets enough calories and fluids as I worry about how little she eats.

I've started going to an Alzheimer's Society support group and a domiciliary (home care) agency now comes every morning to help get Mum washed and dressed. This means that I can get a proper night's sleep. Mum is also eating better now, so I think she was feeling my stress too.

I still keep in regular contact with Katie and find it really reassuring to know that she will be there to help me work through things as Mum's illness progresses."

Ellen from Hatherley



Joining up care for people with lung disease

Photo Credit – Gloucestershire Care Services NHS Trust

Residents in Gloucestershire with a long-term lung complaint can now benefit from more joined up care thanks to changes in respiratory services.

This year, hospital and community services were brought together into a single team to provide seamless care and support between hospital and home.

Between 2012 and 2013 there were over 1,000 emergency hospital visits in Gloucestershire as a result of lung disease - including chronic bronchitis and emphysema.

The team is improving the quality of information and advice people receive to help manage their condition, reduce the amount of time people need to spend in hospital and reduce the likelihood of having to go back into hospital.

The improved service provides a 'one stop shop' - a single telephone number that gives information to GPs and other health professionals on the types of care available.

"I've learned so much thanks to GRT"

Your experience

"When I got home from hospital, Hayley from the Gloucestershire Respiratory Team visited me about my chest problems. She was great and taught me how to use my inhaler more effectively – it has really helped my breathing.

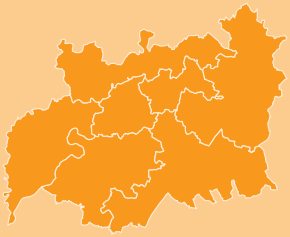
She also gave me a self-management plan to help me recognise when my condition flares up and what to do when this happens. Now I keep prescribed medications at home so that I can take them as soon as I need to.

The first time that happened I was frightened and didn't feel very confident, so I phoned the respiratory team. They reassured me and I did my self-management plan. Since then I feel much more confident and in control.

I also went to an exercise and education group for people with COPD like me. The specialist who had visited me at home was there on my first day which made me less nervous – and I didn't have to repeat everything either. The exercises I did there showed that my oxygen levels had dropped, so I went to see the oxygen nurse in a clinic and now use oxygen on a daily basis.

I've learned so much thanks to the GRT. I am less breathless and much more confident about managing my condition."

Wendy from Gloucester



Weight Management scheme a success

Since September 2013, obese adults in Gloucestershire have been benefitting from a new community weight management scheme.

Jointly commissioned with Gloucestershire County Council, the venture supports people to make long term changes to their eating and physical activity habits in a bid to lose weight and improve their health and wellbeing.

“I’m delighted with the results – I feel so much better”

The free groups, run by Slimming World, are available in every district with one to one time at the end of each session to develop and review personal eating plans. There is also a follow up review session after 6 months.

This scheme is part of our commitment to reduce obesity in the county and over 2800 people have been helped since the service started. We are now looking at how we take this forward over the longer term.

Your experience

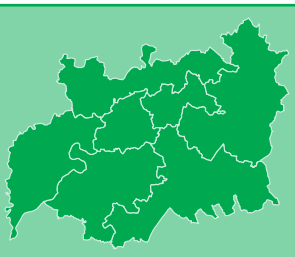
“Last year, my GP referred me to Slimming World for 12 weeks.

I’m absolutely delighted with the results. After 11 weeks, I had lost 1st 10lbs, and started feeling so much better. I now have excellent control over my diabetes and have managed to stop having insulin injections during the day. I’ve also reduced the amount I need at night.

Initially, I really didn’t want to join a slimming club. However, the Slimming World consultant Kathy is really supportive and encouraging, and the other people in the group are very friendly and inspirational.

I’ve decided that I will carry on attending Slimming World to lose even more weight as the health benefits are truly amazing!”

Gaye from Tewkesbury



Pharmacies supporting healthy living

Community pharmacies are boosting their services to help people live healthier lives.

A number of pharmacies in the county are increasing their services and the advice they offer to help people change their lifestyles and improve their health.

These Healthy Living Pharmacies (HLPs) are part of a programme, run by the CCG and county council, that accredits pharmacies for providing a broader range of support services and expert advice.

8 pharmacies have already been granted the HLP quality standard (look out for the HLP logo) with 46 more expected in 2014.

Each HLP has one or more Healthy Living Champions; in-store experts on finding healthy lifestyle information.

To be awarded HLP status, pharmacy teams have to provide advice on a range of health issues, including stop smoking, alcohol, healthy weight, managing a health condition and sexual health concerns.

"I found the team knowledgeable and supportive"

Your experience

"I found the team at the no smoking clinic in Drybrook Pharmacy to be very knowledgeable and supportive.

I have now been a non- smoker for over four months, and without all the help and support from the pharmacy it would have been yet another one of my failed attempts.

I have a very addictive personality which I have fought with for years. Well done and thank you to all the staff."

Sheila from Huntley

Community Diabetes services go from strength to strength

The Gloucestershire Community Diabetes Team is now offering a specialist diabetes service that supports people receiving care from GP surgeries, often reducing the need for patients to go to hospital.

It provides:

- education and training support to healthcare teams within GP surgeries
- education to patients who have recently been diagnosed with diabetes
- support to people with diabetes who live in care homes and;
- diabetes care for patients who have other more complex problems, for example another illness or take other medicines.

We have also agreed to provide more money to improve diabetes care.

This supports education and training and allows GPs and surgery staff to increase their skills and knowledge. They work closely with the Community Diabetes Team to help people achieve and maintain good blood glucose control.

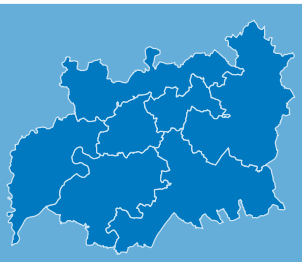
This is helping people to manage their diabetes better and reduce the risk of complications.

"I was very impressed with the service I received"

Your experience

"After visiting the diabetes clinic, I was very impressed by the service I received from Glenda and Emma and the advice given. It has helped me substantially with my diabetes. I learned a great deal and I now understand how, what and when you eat affects your sugar levels. After returning for a follow up with Gail, I was pleased to be told that everything is getting back to normal with my sugar levels. I can only say a great big thank you for the kind service I received."

Michael from Cirencester



Improving Access to Psychological therapies

We are working closely with service providers to further improve mental health services and make the patient's journey through care better.

Initiatives include developing mental health services in GP surgeries to give people rapid access to support closer to home and extending existing hospital liaison teams to allow a comprehensive assessment of a patient's physical and mental health.

We are also improving access to psychological therapies, in particular through services such as Let's Talk.

Let's Talk is free and provides information, guidance and therapy to people at times of stress, anxiety or depression. It works in three ways, by providing:

- signposting to useful information / agencies to help people improve their emotional wellbeing
- guided self-help through either phone support or access to an Emotional Wellbeing educational course
- continuing assessment and treatment to help people find new ways of coping now and in the future through Cognitive Behavioural Therapy.

> ***"I am so grateful that I feel like myself again"***

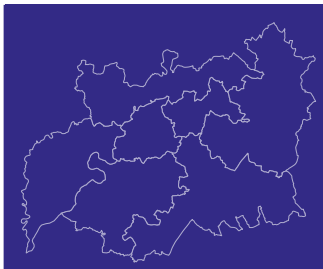
Your experience

"After having my second baby, I was really struggling to cope – I just felt anxious all the time, depressed and really alone.

I decided to phone Let's Talk, which I'd read about at my GP surgery. The lady I spoke to arranged for me to meet with a nurse the next week. The nurse was really helpful, and taught me ways to deal with how I felt. She kept an eye on me, and we met up regularly to talk things through.

This really helped, and I'm so grateful that I feel like myself again. I'm back at work, I've started running again and I even go out once a week with my friends."

Lucy from Cheltenham



Same day service for patients

New Ambulatory Emergency Care (AEC) units at Cheltenham General and Gloucestershire Royal Hospitals are helping to reduce the need for patients to stay in hospital, take pressure off Emergency Departments and most importantly, improves the quality of care.

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

The units at both hospitals can now take patients who have been seen by their GP and GPs are able to call a single telephone number to make arrangements.

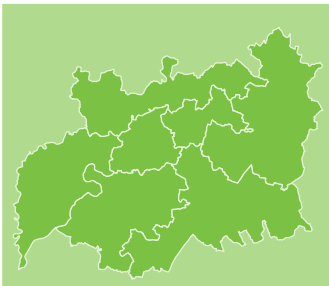
Patients are referred to the service if doctors think there's a good chance that they will be fit to leave hospital within the opening hours of the unit.

"patients are assessed, diagnosed, treated and able to go home the same day"

Your experience

"A short while after kidney surgery, I visited my GP with chest and back pain. My GP referred me to the Ambulatory Emergency Care (AEC) Unit for a chest X-ray and blood tests and I got the results within two hours. Because the tests were inconclusive, I was then given an appointment for a CT scan via the AEC. On both occasions, my experiences within the AEC were outstanding. I would rate the quality of care and timeliness of care as 10/10 and would recommend the service to my family and friends. For me, the AEC service 'stops people worrying' as assessment, diagnostic tests and care is carried out in a timely way."

Susan from Gloucester



Improving care and support to Cancer survivors

"Macmillan support means we can pilot a new service to empower patients"

We are committed to improving care for people living with and beyond cancer, and this year we have formed a major development partnership with Macmillan Cancer Support.

Whilst many more people are now surviving cancer, we know they may be living with the long-term impact of the disease or suffering from side-effects of treatment.

In September 2013 we held a workshop with patients, carers, health professionals and social care colleagues from across the county.

Macmillan's support means we can pilot a new service to empower patients in their own recovery and improve their longer-term health and wellbeing.

The team will include a mix of experienced clinicians, who will also lead on education programmes to ensure expertise in supporting cancer survivors is shared across our Community Teams.

Support will include physiotherapy and occupational therapy to help people return to normal life after cancer. The project will also offer dietary advice, education events and links to partners providing further support and activities.

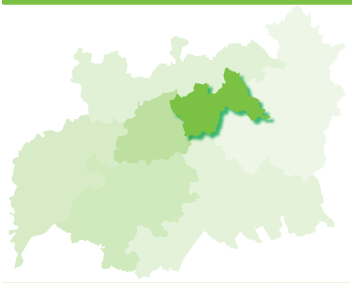
Health awareness is key and the project will be able to reinforce understanding of warning signs, so if needed people can get further hospital treatment quickly.

All of the patient/public quotes in this report are taken from real feedback.
Some photographs and names have been changed to protect patient confidentiality.

Near to where you live

Cheltenham

Tackling Alcohol related attendances at A&E



Pop. approx: 151,016

17 practices

122 GPs

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

The A&E department at Cheltenham General Hospital has seen an increasing number of people with alcohol-related problems.

Cheltenham GPs are working with health partners to improve the follow-up care of patients after their treatment at A&E.

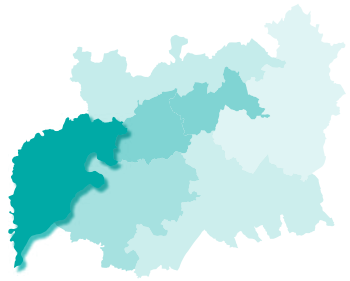
This includes understanding patients' reasons for attending A&E, identifying any possible reasons for alcohol related issues and raising awareness of public health messages. It also involves working with community organisations, such as Turning Point, who can provide information and ongoing support to help people with problems.

The Alcohol Liaison Workers service is being reviewed to make the service more readily available outside of normal working hours when support is often needed most.

Local GP, Dr Julie Jackson with Kevin Macnamara from Turning Point.

Forest of Dean

'Social Referral Hub' launched



Pop. approx. 62,283

11 practices

58 GPs

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

The Forest of Dean locality have set up and funded a 'Social Referral Hub', located within the District Council Offices, to support people who go to their GP surgery, but do not necessarily have a clear medical need.

Half of the GP surgeries in the Forest of Dean started the 6 month pilot on 31 March 2014 and the other half started in May.

People are referred to the Hub by the surgery and are signposted to an appropriate service within the local area.

The project team involves GPs, Forest of Dean District Council, Gloucestershire County Council, Age UK Gloucestershire, Independence Trust, Carers Gloucestershire and Gloucestershire Rural Community Council.

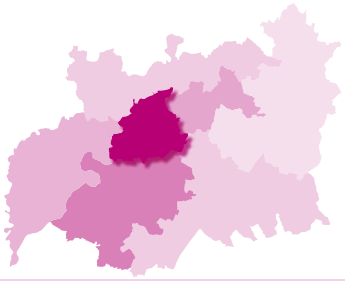
The pilot was based on evidence from similar projects across the country and from existing schemes run by the District Council and other organisations.

The main service supporting the person ensures that other organisations are involved, as required, and takes responsibility for following this through, including providing the report back to the GP.

The Hub will keep up to date with the services and opportunities available to people.

Gloucester

GPs support more care in the home



Pop. approx: 164,554

19 practices

120 GPs

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

The GP surgeries in Gloucester City locality, which includes Brockworth and Churchdown, have spent the year taking forward key priorities within their community plan for care.

Extra GP services are now available in care homes to better support older people and GP support is also available at the local Great Western Court Centre.

This is a place where older people are looked after for a short while to help them get ready for going back home after being ill in hospital.

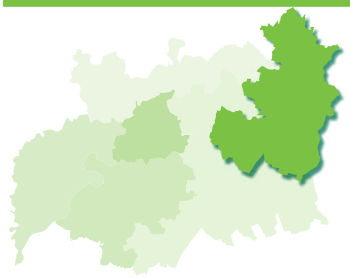
Local doctors, health and care staff within the City are also working closely together so that more people can be looked after in their home rather than going to hospital. Over £1m extra money is being spent to do this.

This is about making sure care is provided in the right place at the right time to meet the patient's needs.

Integrated Community Team members

North Cotswolds

Reaching out to Carers



Pop. approx: 28,198

5 practices

26 GPs

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

Local GPs have been working with community partners to respond to the health needs of an ageing population and support carers.

Many frail, unwell or disabled people are reliant on the long-term care of family members.

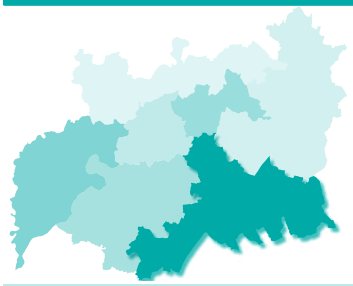
This dedicated work is of immense value and GPs have contributed to changes that will enable all carers to access a Carer's Health Check at their surgery. The initiative will help identify any health issues that require care and provide links to support and advice available in the community.

During this year, the locality GP Executive will be consulting on what more they can do to reach out to carers. They will be testing ideas such as surgeries hosting special carer's afternoon events.

North Cotswolds Locality Executive Group

South Cotswolds

Dementia care 'a priority'



Pop. approx: 57,143

8 practices

49 GPs

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

One of the locality's aims is to improve the diagnosis and recording of dementia in GP surgeries and work with partners to help patients and their carers access the right support.

GPs across the South Cotswolds recently attended a dementia training event and all practices have adopted a Test Your Memory (TYM) tool for assessing patients.

Patient information (including leaflets) and sign posting to community support has improved.

The Locality Executive, in partnership with local partners, has also started its 'social prescription pilot' with two GP surgeries in March 2014.

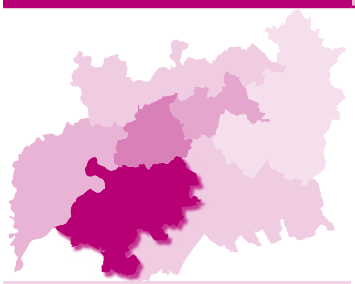
This scheme involves referring patients to a 'hub' where a specially trained hub co-ordinator has knowledge of all schemes running in the local area at any one time.

In discussion with the patient, they can direct them to the support which best suits their needs.

Sarah Clifton-Gould, Healthy Communities Officer and Hub Co-ordinator

Stroud and Berkeley Vale

Memory Cafés – providing advice and support



Pop. approx: 119,512

20 practices

108 GPs

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

As part of its plans to meet local needs, the Locality Executive has funded four memory cafés in Stroud, Cam, Wotton and Berkeley.

The cafés are sited within sheltered housing complexes, but 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 who use the sessions to give support to patients and their carers.

The weekly 2 hour 'drop in' sessions, give people the chance to have a chat and a coffee and there are a range of activities for people to enjoy.

The project has three key aims:

- Helping people to feel part of the local community
- Carer support
- Access to advice and guidance.

'Let's Get Together: Marybrook Medical Centre's Memory cafe'

Tewkesbury, Newent and Staunton

Patients benefit from ECG test in local surgeries

Pop. approx 42,115

5 practices

21 GPs

Covering Tewkesbury, Newent, Staunton, Corse

Patients across the locality are now able to access 24 hour electrocardiogram (ECG) tests within their local GP surgery to investigate things like dizzy spells, blackouts (syncope), tiredness or breathlessness.

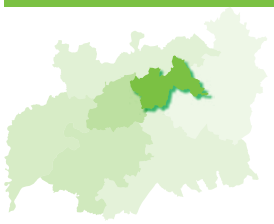
As a result patients are able to travel locally for their appointments, at a time to suit and receive their results quickly.

Further patient feedback will be looked at this year to inform development of this service moving forwards.

GPs and practice staff meet regularly to discuss other opportunities for developing local services, and will be looking into opportunities with partners in health and social care.

Member Practices by locality

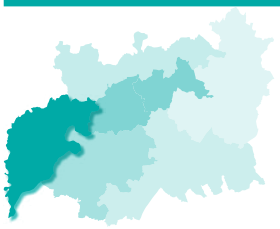
Cheltenham



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

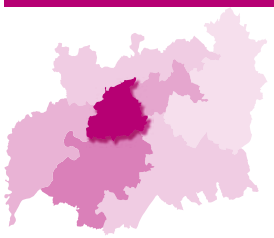
Forest of Dean



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

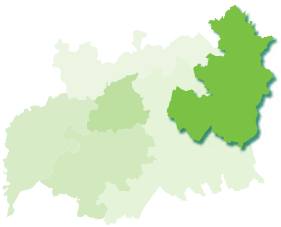
Gloucester City



Gloucester City Locality:

Barnwood Medical Practice
Bartongate Surgery
Brockworth Surgery
Cheltenham Road Surgery
Churchdown Surgery
College Yard Surgery (The)
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

North Cotswolds

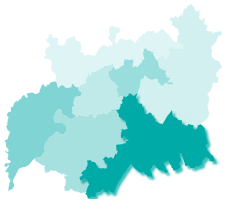


North Cotswolds Locality:

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

Member Practices by locality

South Cotswolds



South Cotswolds Locality:

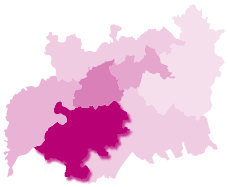
Avenue Surgery (The)
Hilary Cottage Surgery
Medical Centre, Lechlade (The)
Park Surgery (The)
Phoenix Surgery
Rendcombe Surgery
Romney House Surgery
St Peter's Road Surgery

Tewkesbury, Newent and Staunton

Tewkesbury, Newent and Staunton Locality:

Church Street Practice (The)
Corse (The Surgery)
Jesmond House Practice
Newent Doctors' Practice
Watledge Surgery

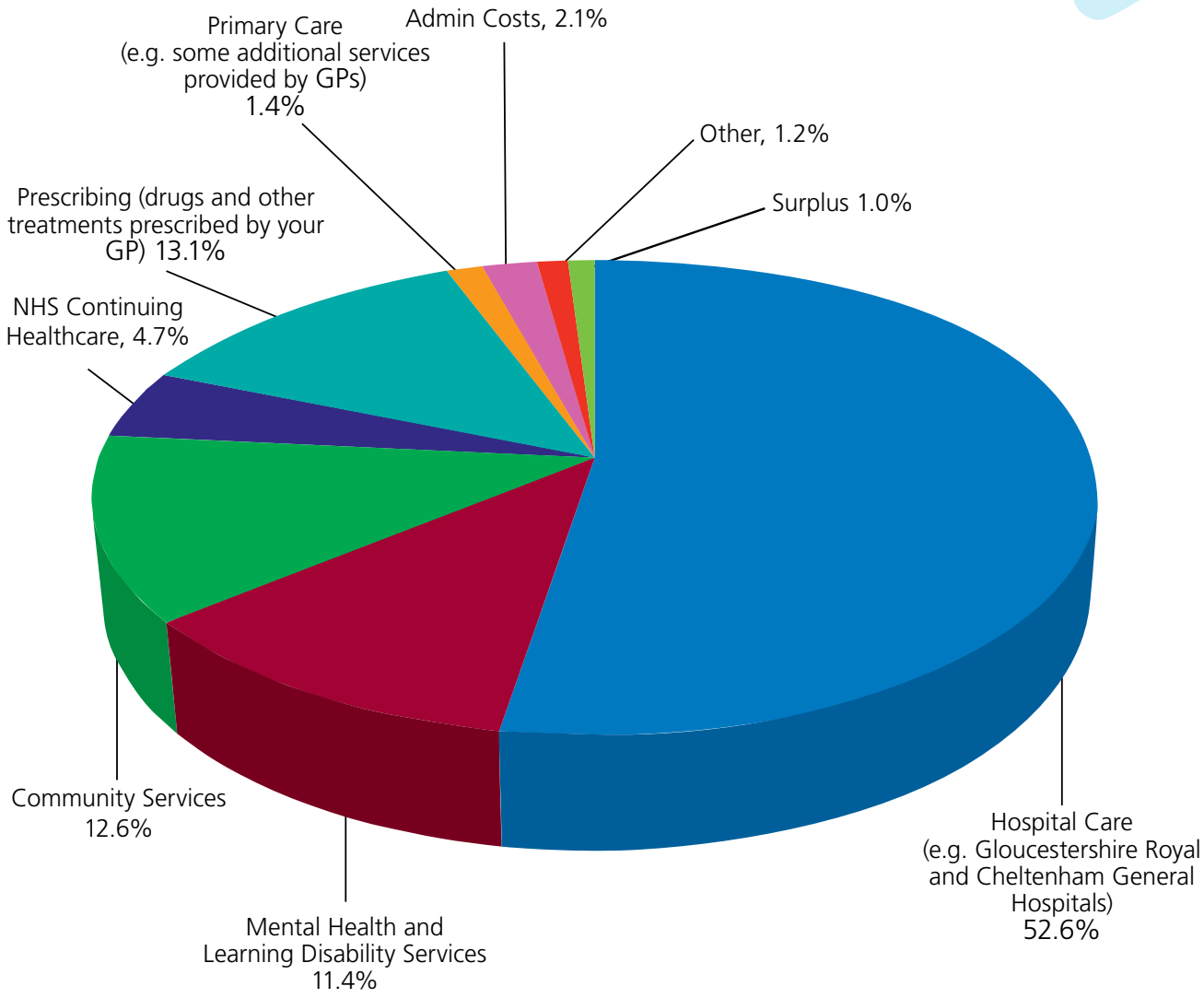
Stroud and Berkeley Vale



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
St Luke's Medical Centre
Stonehouse Health Clinic
Stroud Valleys Family Practice
Walnut Tree Practice

How the money is spent



The CCG's budget for 2013/14 was

£678.9m

This equates to around £1,088 per Gloucestershire resident.

The pie chart shows how the money was spent (by category)

Strategic Review

NHS Gloucestershire Clinical Commissioning Group was established without conditions on the 1st April 2013. The CCG is a membership organisation with 84 member GP practices grouped into seven localities. All member practices are within Gloucestershire.

The Population We Serve

The CCG serves a GP registered population of 624,000. In Gloucestershire there is already a significant proportion of the population aged over 65 years; and this is also growing at a faster rate than most of the rest of the country.

According to the latest Office for National Statistics (ONS) projections, the number of people aged 65 and over in Gloucestershire will increase by about 70% (or 78,300) between 2010 and 2035 and will account for nearly one third of the total population. In contrast, the number of young people and people of working age is likely to remain similar or even slightly decrease.

Our Responsibilities

The CCG is responsible for commissioning (buying) community health services, mental health services, learning disability services, secondary health care (hospital) services, primary care prescribing (prescribing of medicines by GPs and nurses) and locally enhanced services (e.g. additional services provided by GP surgeries).

NHS England and Gloucestershire County Council are responsible for the commissioning of primary care contractors, public health services or specialist services and the CCG works closely with these commissioners to ensure that care and support is joined up.

We certify that the clinical commissioning group has complied with the statutory duties laid down on the National Health Services Act 2006 (as amended).

Gloucestershire Health & Social Care Community

Within Gloucestershire the main NHS providers are Gloucestershire Hospitals NHS Foundation Trust (acute hospital services), Gloucestershire Care Services NHS Trust (community services) and 2gether NHS Foundation Trust (Mental Health and Learning Disability services).

There are a number of other NHS service providers within the county, such as South Western Ambulance Service NHS Foundation Trust, a number of private providers who offer NHS Services and an extensive voluntary sector.

Services are also commissioned from providers who border Gloucestershire. We have established relationships with all of these key additional providers who provide services in our county to ensure the best outcomes for patients and value for money. We also ensure they remain an important partner in the health and social care community.

Review of the Year

The CCG set out its objectives at the start of the year, these were to:

1. Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on a clinical programme approach (programme groups led by GPs that look at particular health conditions e.g. Cancer and the patient's journey through care) and developing our member localities
2. Work with patients, carers and the public to inform decision making
3. Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation
4. Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities
5. Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers
6. Develop strong leadership as commissioners at all levels of the organisation, including localities.

Delivery against these objectives has been reported to each Governing Body meeting and achievement against key areas of development against each objective in year is given below.

1 Develop strong, high quality, clinically effective and innovative services. We will deliver this through a multi professional focus, with a particular emphasis on a clinical programme approach and developing our member localities

Localities

The CCG has seven Localities which vary considerably in geographical size and patient population.

The Localities are headed by Locality Executive Groups, the membership of which varies but, as a minimum, it includes a GP Chair, CCG Liaison GP and local GPs.

The role of the Locality Executive Group is to support the improvement of local health services through understanding the health service needs of their Locality and use this knowledge to develop local priorities.

The Localities, by their nature, offer an important opportunity to ensure that countywide strategic decisions are informed by, and relevant to, the locality populations.

Each Locality Executive, working with local partners, developed a locality plan in 2013/14. The plans reflected some of the differing/specific needs of local communities that cannot be dealt with at a county wide level.

During the year, the localities also started to develop strong links with Public Health, District Councils and local voluntary organisations to develop shared local priorities and start pieces of joint working, particularly around social prescribing (GPs referring patients to other community services and support) and health promotion.

Clinical Programme Groups

The CCG has further developed its Clinical Programme Groups (CPGs) in 2013/14. These groups bring together a range of healthcare professionals and now include lay (public) members.

The CPGs form a key part of the CCG's structure to help deliver the CCG's strategy through reviewing and developing priority clinical pathways (the patient's journey through care) to develop improved care and health outcomes.

Key developments in year included:

- Respiratory CPG - A key outcome of this group has been the formation of the Gloucestershire Respiratory team where the Community Respiratory Team and the hospital-based Respiratory Assisted Discharge Team have come together. This team will improve the quality of information and advice people receive, reduce lengths of stay in hospital and support GPs and surgery staff in managing complex patients. It provides urgent assessment within 48-72 hours of referral, with non-urgent referrals being seen within 14 days, supported discharge (the transfer of patients from hospital to home), home oxygen assessments, outpatient clinics and pulmonary rehabilitation.
- Musculoskeletal (conditions affecting the muscles, bones and joints) CPG - The programme group developed the patient's journey through care (clinical pathways) to offer alternative options for community services and support.

Other examples of the work carried out by the CPGs can be found in the early pages of this Annual Report.

2 Work with patients, carers and the public to inform decision making

In the Autumn, the CCG started a consultation with the Health and Social Care Community on the future challenges and opportunities for health and care services in Gloucestershire.

Following this, the CCG launched an 8 week public consultation ('Joining up your Care') in January.

The objective of the JUYC exercise was to enable individuals and groups to access information on the challenges and opportunities facing health and social care and offer a range of opportunities to feedback on the themes of prevention and self-care, caring for people in the community and at home and specialist hospital care.

This engagement exercise ended on 28 February and the outcome report on feedback has now been published and informed the CCG's two year and five year plans from 2014/15 onwards.

3 Transform services to meet the future needs of the population, through the most effective use of resources; ensuring the reduction of harm, waste and variation

Urgent care

A key focus for the CCG and the Gloucestershire Health & Social care community is creating an improved urgent care system and all partner organisations have been involved in significant work in 2013/14 to support this.

This work is led through the Urgent Care Network Board and there are weekly meetings attended by Chief Executives and Directors who review actions particularly around discharge (arrangements for patients to leave hospital), in order to tackle this high priority area.

This ensures rapid senior decision making where required to support services and service developments.

An Urgent Care Plan has been agreed with four defined areas of work: pre-hospital, in hospital, discharge and community care, and system enablers. This has increased clarity relating to the priority projects that are expected to make a difference to patients and the urgent care system. These schemes include:

- Greater use of the countywide Community Minor Injury Units
- Implementation of the Older People's Assessment and Liaison (OPAL) service
- Implementation of an Ambulatory Care model for Gloucestershire - the new Ambulatory Emergency Care (AEC) Units at Gloucestershire Royal and Cheltenham General Hospitals are now taking GP referrals and providing same day emergency care to patients
- Roll out of the Integrated Community Teams, incorporating high intensity services and Rapid Response
- A review of the use of interim beds
- A project that will reduce delays in accessing reablement services
- Review of Community Hospital beds, with the aim of increasing diverts from the Emergency Departments
- Reviewing community alternatives to Emergency Department attendance
- Pilot of a General Practitioner (GP) working within the Emergency Department
- Enhancing discharge arrangements – new joint integrated discharge team from April.
- NHS 111 implementation – this contract replaces the national NHS Direct service and has been procured and implemented with other CCGs. The service experienced operational issues initially, but these have been largely resolved. The provider is working very closely with the CCG to ensure continuous improvement in services
- Non Urgent Patient Transport Services procurement – this service was re-procured and went live in December

A key part of the urgent care strategy is the introduction of rapid response and high intensity services (provided by the Integrated Community Teams) in order to develop the capacity and capability of community services. This is helping to reduce demand on hospital services. This was initially launched in Gloucester City and then Cheltenham before wider roll out across the county during 2014.

The CCG has also introduced a 24 hour single point of clinical access (SPCA) which provides information to doctors on the availability of community services.

Planned Care

The CCG has also made significant progress in planned care services during 2013/14. Through its Clinical Programme Groups and Locality Executive Groups, clinicians and managers have been working to improve the patients' through journey care, reducing pressure on hospital services and developing community based services.

Highlights include:

- Improving access to diagnostics e.g. endoscopy, ultrasound, CT and MRI – from an increased range of community locations
- Joining up respiratory services – hospital and community respiratory services brought together into a single team to provide seamless care

- More proactive and planned GP support to care homes (care homes enhanced service)
- Cancer services and support – significant investment in GP education to support early diagnosis and a major new development partnership initiative with Macmillan to support and empower Cancer survivors
- Mental health services – developing services in GP surgeries to give people rapid access to support closer to home and extending existing hospital liaison teams to allow a comprehensive assessment of a patient's physical and mental health. The CCG is also improving access to psychological therapies e.g. Let's Talk.
- Learning disability services – forming a health and social care intensive community support service for people with complex and challenging behaviour and increasing the number of people receiving an annual health check and a health action plan.

Integration

Integration is a core component of the strategic approach in Gloucestershire; including the focus within the Better Care Fund.

In 2013/14 the CCG, together with partners, began the roll out of strengthened Integrated Community Teams, beginning with Gloucester City. Our ICT's bring together occupational therapists, physiotherapists, social workers, reablement workers, community nurses, administrative and other support staff to work as one team providing support typically around 4 GP practices with a combined population of around 30,000 patients. Future developments will include integrating with mental health services and development of pathways with the wider voluntary and community sector.

4 Build a sustainable and effective organisation, with robust governance arrangements throughout the organisation and localities

The CCG approved its constitution and through the year has reviewed its sub committees against the requirements for the CCG.

The NHS Constitution imposes a statutory duty on each CCG to have a priority setting system in place that explains how the CCG decides whether to fund a healthcare intervention or service.

The CCG also has a duty to publish the decision-making process on its website. As a result of this the CCG has recently set up a Priorities Sub Committee and adopted an ethical framework and prioritisation framework.

Details of the CCG's governance structure are given in the Statement of Internal Control.

5 Work together with our partners to develop and deliver ill health prevention and care strategies designed to improve the lives of patients, their families and carers

Working In Partnership

During the year the CCG has developed, and is continuing to develop, relationships with other organisations both within Gloucestershire and outside in order to help to deliver its strategic objectives.

The CCG has representatives on the following groups:

- Gloucestershire Health and Wellbeing Board
- Strategic Clinical Networks
- NHS England Commissioning Assembly
- NHS Clinical Commissioners
- The Clinical Research Network West of England Partnership Group
- West of England Academic Health Science Network (WEAHSN)
- Specialist commissioning collaborative
- Clinical Senate Council and Assembly.

Links have also been established with District councils, the Voluntary sector and HealthWatch.

The CCG has a strong working relationship with Gloucestershire County Council with joint arrangements for mental health, learning disability and community services.

During the year the following joint strategies have been adopted by both organisations and are being implemented with joint working groups which involve a range of stakeholders:

- Mental health and wellbeing strategy – high level strategy, linked to the national strategy *'No Health without Mental Health'*
- Adult autism strategy – Gloucestershire has developed a joint adult autism strategy in year which has seven overarching aims.

Both of these strategies are being taken forward by cross community working groups.

Gloucestershire Health and Wellbeing Board

The CCG is an active partner of the Gloucestershire Health and Wellbeing Board. Led by the County Council, the Board has developed a joint health and wellbeing strategy to help tackle the challenges of the future and to support communities.

Key priorities are:

- Tackling health inequalities
- Improving mental health
- Reducing obesity (promoting healthy weight)
- Improving health and wellbeing into older age
- Reducing the harm caused by alcohol.

A delivery plan has been developed involving all organisations represented on the Board.

A key part of the joint working between partners this year has been the development of a plan for the Better Care Fund. This will total £11.596m in 2014/15 and £39.948m in 2015/16. The plans include a vision for the future that requires whole system change, how we commission work from providers and how providers interact with service users and with each other. Working together with the County Council as co-commissioner, the CCG is committed to supporting changes to lifestyle behaviour and attitudes with a key role for the third sector and not least our citizens themselves.

6 Develop strong leadership as commissioners at all levels of the organisation, including localities

The CCG has made significant progress in establishing strong leadership as a commissioner in 2013/14. Details of how this has been achieved can be found in the Strategic Review (localities, clinical programme groups), the Governing Body Report and the Governance Statement.

Our performance highlights 2013/14

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

Breakdown of current year to date performance by RAG status of indicator			
	Green	Amber	Red
NHS Gloucestershire Clinical Commissioning Group	14	1	6
Percentage	67%	5%	29%

	2013/14 actual	2014/15 forecast
The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis	Green	Green
The percentage of non admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period	Green	Green
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period	Green	Green
Diagnostic test waiting times – under 6 week waits	Green	Green
All cancer 2 week waits	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
Ambulance clinical quality – Category A – 8 (Red 2) minute response	Green	Green
Ambulance clinical quality – Category A 19 minute transportation time	Green	Green
Mental Health Measure – care programme approach 7 day follow up on discharge	Green	Green

However, there are some areas where the performance has fallen short of the required targets or standards in 2013/14 which require particular attention in the year ahead to improve performance. These are:

	2013/14 forecast	2014/15 forecast
Four hour A&E target	Red	Amber
Ambulance clinical quality-Category A – 8 (Red 1) minute response	Red	Green
Mixed sex accommodation breaches GHFT undertook a reconfiguration of services, this resulted in a number of breaches, the reconfiguration is now complete and this is not believed to be an ongoing issue	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): Additional consultants recruited, diagnostic pathways revised	Amber	Amber/Red Delivery from the end of Q1
Two week wait for breast symptoms (where cancer was not initially suspected)	Red	Amber
Cancelled operations not rebooked within 28 days	Red	Green
Referral to Treatment pathways greater than 52 weeks	Red	Green

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

Financial Summary

The CCG set a balanced budget at the start of the financial year with a planned surplus of £6.757m. At the end of the financial year the CCG has delivered a surplus of £6.806m which is in line with the plan. The allocation received by the CCG continued to change during the financial year as issues with the baseline transfers to new commissioning organisations were resolved; this caused some financial pressures in year.

During the year demand for services continued to rise, particularly in emergency care and certain planned care specialities which meant that many more patients were seen compared to planned numbers. This led to the CCG spending more than budgeted for these services, however, this was offset, in financial terms, through underspends in some other services and also through the use of activity and contingency reserves, in order to achieve the surplus of £6.806m.

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

Details of how the clinical commissioning group has discharged its duties under certain sections of the NHS Act 2006 (as amended);

There are a number of requirements for CCGs in the NHS Act 2006 (as amended) in respect of items to be included in their Annual Report. These requirements are:

- 14Z15(2)(a): Explain how the clinical commissioning group has discharged its duties under section 14R (duty as to secure continuous improvement in quality of services):

The CCG has developed a quality strategy in year. This strategy underpins all developments within the CCG and also ongoing contract monitoring of providers to enable the CCG to ensure that quality improvement is driving service redesign and also implicit within the contracting for existing services. 14Z15(2)(a): Explain how the clinical commissioning group has discharged its duties under section 14T (duties as to reducing inequalities).

The CCG is tackling inequalities through several routes. The development of the two and five year plans started by reviewing the Joint Strategic Needs Assessment to identify specific areas of inequality within the population and ensure that plans were focussed on these areas with the remit of reducing inequalities over the period of the plan. In year, all service developments have had equality reviews to ensure that as a minimum they did not increase any inequality and as a standard they started to address any identified inequalities within the area under review. Locality plans within the seven GP localities have specifically looked to address inequalities at a very local level.

- 14Z15(2)(a): Explain how the clinical commissioning group has discharged its duties under section 14Z2 (public involvement and consultation by clinical commissioning groups);

  The CCG has undertaken a consultation this year on the development of its two year plan and five year strategy called 'Joining Up Your Care'. This consultation started on the 2nd January and finished on the 28th February and was preceded by pre-engagement work with Localities, local providers, the County's Health and Care Overview and Scrutiny Committee (HCOSC), HealthWatch, the NHS Reference Group and an equality impact assessment was carried out.

  The consultation consisted of stakeholder engagement events, public drop in sessions in every locality, targeted events and survey work with seldom heard groups, printed engagement booklets, media features, video animations, social media and an online survey.

  The CCG has also undertaken a range of other events to ensure that there has been appropriate clinical and community engagement in the development of new service specifications. This includes the Out of Hours primary care service specification.

- 14Z15(2)(b): Review the extent to which the clinical commissioning group has contributed to the delivery of any joint health and wellbeing strategy to which it was required to have regard under section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007.

  The CCG is a member of the Gloucestershire Health and Wellbeing Board (H&WB) and a has helped to develop the H&WB strategy. Delivery of the strategy is being taken forward jointly by the CCG and Gloucestershire County Council.

We certify that the clinical commissioning group (through the Accountable Officer) has complied with the statutory duties laid down in the National Health Services Act 2006 (as amended).

2 year and 5 year plan – Joining Up Your Care

As described earlier in the report, the CCG has spent time in year consulting on and developing a two year plan and five year strategy. The planning process for the two year plan is complete. The five year plan will be completed in June.

Our ambitions are to ensure:

- People are provided with support to enable them to take more control of their own health and wellbeing. Those that are particularly vulnerable will benefit from additional support
- People are provided with more support in their homes and local communities where safe and appropriate to do so, thus moving away from the traditional focus on hospital-based care
- When people need care that can only be provided in a hospital setting, it is delivered in a timely and effective way.

Priority areas the CCG and its partners are looking at:

- Focus on joined up care through the rollout of Integrated Community Teams and the bringing together (Integration) of some specialist teams
- Living Well – a model which places the person/patient/client at the centre of care and community support
- Increasing focus on Prevention and Self Care e.g. Weight Management, Health Living Pharmacies, Telecare, and Telehealth
- Delivering a consistent primary care (GP) offer with clarity regarding their role in supporting out of hospital care and management for vulnerable patients over 75 years
- Delivering key changes within priority clinical programme groups, including Musculoskeletal, Respiratory, Ophthalmology, Paediatrics, Cancer, Cardiovascular disease, Frail Older People and Diabetes
- Ensuring further improvements to the urgent care system with a focus on:
  - developing community services (alternatives to having to go to hospital),
  - looking at how patients access care and treatment when they arrive at the Emergency Department front door and;
  - a joined up approach to supporting patients to leave hospital when they are medically fit to do so.
- Ensuring consistency of planned (non-emergency) care through a systematic approach to managing demand for services and reducing variation in the quality, and access to care
- Ensuring a collaborative approach to specialist commissioning (very specialist care), with well integrated (joined up) care.

Principle Risks

The CCG has identified a number of key risks to the achievement of its strategic objectives. Major risks are outlined below

- Pressure of work within primary care prevents full engagement in transformational change
- Level of transformational change and associated financial impact is not realised, impacting ability to deliver recurrent savings
- Ability to balance resource for individual organisational priorities and collaborative working priorities compromised by the scale of the future financial challenge
- Demographic growth is higher than anticipated, creating a demand pressure within services
- Significant shifts in the shape of the service provision fail to gain sufficient public and political support
- Pace of cultural change is not sufficient to deliver the changes required.

Investments

The table below shows the CCG's programme allocation increase for 13/14 onwards. The figures from 2016/17 represent estimates based on NHS England planning assumptions. Investment decisions are prioritised using the CCG's prioritisation framework with those required to meet national objectives including NICE, population and demand growth given a higher weighting. Investments in 2013/14 and 2014/15 are into community based services and also in transformational change.

	2013/14 £m	2014/15 £m	2015/16 £m	2016/17* £m	2017/18* £m	2018/19* £m
Programme Cost Allocation	653.538	667.524	678.872	691.092	702.840	714.789
Programme Allocation Growth	15.193	13.986	11.348	12.22	11.748	11.949
Programme Allocation Growth		2.14%	1.7%	1.8%	1.7%	1.7%

*forecast allocation increases based on NHS England planning assumptions

Sustainability

Details of how the CCG has delivered against the sustainability agenda are given in the Sustainability section of this report.

The CCG occupies Sanger House in the Gloucester Business Park. The lease for this property transferred from Gloucestershire PCT to NHS Property Services on the 1st April 2013 and the CCG leases space within the building from NHS Property Services. Further information can be found in the sustainability report on page 46.

Equality Report

In line with the requirements of the Equality Act 2010 and associated public sector equality duty we have published our equality objectives and annual equality report on our website, for more details please visit http://www.gloucestershireccg.nhs.uk/

Since the publication of the equality report we have revised our strategy and action plan for promoting equality and reducing health inequalities. Currently we are working to establish an Equality/Health Inequality Focus Group to facilitate the implementation of action that we have identified in a systematic and timely fashion. Our ultimate aim is to integrate equalities (including health inequalities, inclusion and Human Rights) issues in every stage of the commissioning cycle.

We are always keen to hear from of our service users and employees on how we can improve patient outcomes and experiences of our services and how we can improve the skills and working conditions for our workforce.

Please find below a breakdown at the end of the financial year showing:

- The number of persons of each sex who were on the Governing Body
- The number of persons of each sex who were employees of the clinical commissioning group.

	Male Headcount	Female Headcount
Governing Body members	13 including one external	9 including 2 external
All CCG employees	53	133

Mary Hutton
Accountable Officer

3 June 2014

Quality, Safety and Compliance

During the first year of the CCG we have instituted robust assurance systems that support the quality improvement agenda across the county's service providers.

The Governing Body has established the Integrated Governance and Quality Committee, which comprises both clinical professionals and lay members of the board. The committee meets bi-monthly and receives a comprehensive quality report regarding our local service provider's performance. This report contains information on clinical effectiveness; clinical audit; patient safety including serious incidents; the safety thermometer, including pressure ulcers and falls prevention; healthcare acquired infections and CQC inspections. In addition reports on child and adult safeguarding are presented including any serious case reviews.

Other quality and safety assurance processes introduced by the CCG include regular clinical quality review group (CQRG) meetings with each service provider. Members of the CCG Quality Team attend the provider quality committees and have made site visits to a wide range of clinical settings across Gloucestershire. The Quality Team also contribute to the quality monitoring of ambulance and out of hours services, as well as independent healthcare providers and care homes.

The CCG has worked together with our local NHS providers to achieve a number of national and local CQUINs (Commissioning for Quality and Innovation). This included a focus on improving services for patients with dementia; reducing pressure ulcers, falls and deep vein thrombosis (DVT), and assuring that patients with mental health conditions have good access to physical health services.

Learning from patient experience is an important component of the quality assurance process. The CCG has introduced 'Patient Stories' at the start of Governing Body meetings, providing insight into the local services from a user's perspective. The CCG also provides a PALS and complaints service which assists the CCG to understand where the services could be improved and lessons learned.

The CCG Quality Team has also been working in conjunction with colleagues in social care and public health to have a shared approach to quality assurance across the wide range of services we commission together.

The Governing Body has agreed the CCG quality strategy 'Our Journey for Quality', and the implementation plan to support this is now in the process of being implemented.

Governing Body Report

The CCG Governing Body is accountable for exercising the statutory functions of the group, it may however, delegate authority to any of its members, its governing body, employees or a committee or sub-committee of the group.

The extent of the authority to act depends on the powers delegated to them by the group as expressed through:

a. the group's scheme of reservation and delegation; and

b. the terms of reference of committees.

The majority of CCG functions have been delegated to the CCG's Governing Body. The role of the Governing Body is corporate responsibility for the CCG's strategies, actions and finances.

As an NHS organisation, it provides stewardship and remains publicly accountable. The Governing Body has GP representation from each of the seven localities and the Governing Body has been further strengthened with the appointment of Lay Members, a Registered Nurse and a Secondary Care Doctor.

This has helped to bring a diversity and range of capabilities and capacities to bear on CCG business and leadership. The Governing Body has an assurance framework system in which significant risks to the CCG's major objectives are managed. The board assurance framework helps to drive the board agenda and focus.

Reporting to the board are committees responsible for audit; integrated governance and quality; and remuneration. Full details of these sub committees are given in the Statement of Internal Control.

Governing Body Members are listed below:

		From – to	Member of Audit Committee
Clinical Chair	Dr Helen Miller	1st April 2013 – present	N
Deputy Clinical Chair	Dr Andy Seymour	1st April 2013 – present	Y
GP Locality – Tewkesbury	Dr Jeremy Welch	1st April 2013 – present	N
GP Locality – South Cotswolds	Dr Malcolm Gerald	1st April 2013 – present	N
GP Locality – North Cotswolds	Dr Caroline Bennett	1st April 2013 – present	N
GP Locality – Gloucester	Dr Will Haynes	1st April 2013 – present	N
GP Locality – Cheltenham	Vacant	1st April 2013 – present	N
GP Locality – Forest of Dean	Dr Martin Gibbs	1st April 2013 – present	N
GP Locality – Stroud	Dr Charles Buckley & Dr Hein Le Roux (job share)	1st April 2013 – present	Y
Director of Adult Social Care	Margaret Willcox	1st April 2013 – present	N
Acting Director of Public Health	Dr Alice Walsh	1st April 2013 - present	N
Registered Nurse	Julie Clatworthy	1st April 2013 – present	N
Secondary Care Specialist	Dr Steve Allder	1st April 2013 – present	N
Lay Member Governance	Colin Greaves	1st April 2013 – present	Y (Chair)
Lay Member Business	Valerie Webb	1st April 2013 – present	Y
Lay Member PPE	Alan Elkin	1st April 2013 – present	Y
Lay Member PPE	Rob Rees	1st April 2013 – 31st December 2013	N
Accountable Officer	Mary Hutton	1st April 2013 – present	N
Director of Commissioning Implementation	Mark Walkingshaw	1st April 2013 – present	N
Chief Financial Officer	Cath Leech	1st April 2013 – present	N
Director of Quality & Assurance	Dr Marion Andrews-Evans	1st April 2013 – present	N
Director of Transformation & Service Redesign	Jonathan Jeanes	29 July 2013 – 31st March 2014	N

Information on Governing Body declarations of interest are given in the Remuneration Report.

There are no post balance sheet events for the CCG.

Pension liabilities

Details of pension liabilities and how their treatment is given in note 6.5 within the Financial Statements and within the Remuneration Report.

Sickness absence data

Details of the level of sickness absence are given in note 6.3 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 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 and ill health retirements in 2013-14

	Number
Total days lost	786
Total staff	126
Average working days lost	**6**

Average working days lost has been calculated by NHS England and is based on the period April 2013 to December 2013 inclusive.

	Number
Number of persons retired early on ill health grounds	Nil
Total additional Pensions liabilities accrued in the year	Nil

Ill health retirement costs are met by the NHS Pension Scheme.

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

External audit

The CCG's external auditors are Grant Thornton UK LLP. The cost of the annual statutory audit of the 2013/14 Financial Statements was £116,000.

Disclosure of "serious untoward incidents"

Details of serious untoward incidents are given within the Governance Statement.

Setting of charges for information

We certify that the clinical commissioning group has complied with HM Treasury's guidance on cost allocation and the setting charges for information.

Principles for remedy

HM Treasury's Managing Public Money contains guidance at Annex 4.14 about the steps public bodies should take where they have caused injustice or hardship by maladministration or service failure.

The Parliamentary and Health Service Ombudsman published a revised Principles for Remedy in May 2010, setting out six principles that represent best practice and are applicable to clinical commissioning group.

NHS Gloucestershire Clinical Commissioning Group is committed to providing any service user, member of their family or a carer, member of the public, stakeholder or member of staff, with the opportunity to provide feedback on services commissioned or provided by the organisation, including making a formal complaint.

For the period covered by this Annual Report and Accounts, the Policy and Procedure has complied with the responsibilities for NHS organisations set out within the Local Authority Social Services and National Health Service Complaints England Regulations 2009 (and Clarification of the Complaints Regulations issued January 2010), which came into effect from 1 April 2009 and has paid due regard to the Health Service Ombudsman's Principles of Good Complaint Handling, which were reprinted with minor amendments on 10 February 2009.

Accessible leadership and responding to staff (Employee consultation)

NHS Gloucestershire Clinical Commissioning Group is a significant employer and larger than many CCGs. The workforce is made up of employees from a wide variety of professional groups, 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 national Agenda for Change terms and conditions handbook who have members employed within 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. This approach has worked well in the first year as a CCG although arrangements may be reviewed in light of our Business Plan to consider where arrangements may be strengthened going forward.

The CCG has delegated negotiations over HR policy development to the Central Southern Commissioning Support Unit (CSCSU) Staff Partnership Forum. The CSCSU 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 ratified and adopted by the CCG's Integrated Governance Committee prior to publication.

The CCG has an organisational development plan 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 team briefing sessions – the Accountable Officer and Clinical Chair hold monthly briefing sessions for all staff, including Commissioning Support Unit staff. These briefings cover all aspects of the CCG's business including financial and performance positions, policies and procedures and developments. This is complemented by issue of a written Monthly Team Brief bulletin which follows the meeting
- Development of 'CCG Live' which holds information on all team briefs, policies, procedures and other information
- A monthly coffee morning is hosted on rotation by each department attended by all CCG staff and Directors in the building at the time
- The CCG executive team meet 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.

Staff Survey

The CCG has also recently asked all staff to participate in a staff consultation. The results of the survey are currently being analysed and will be used to develop an action plan for any areas of improvement identified through the survey.

Disabled employees

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

Our aim is to operate in ways which do not discriminate our potential or current employees with any of the 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.

We publish our employee profile by each of the nine protected characteristics, this helps us to identify and address areas of under-representation in a systematic manner as and when opportunities arise.

Emergency preparedness, resilience & response

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS England Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

Statement as to 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 clinical commissioning group'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 clinical commissioning group's auditor is aware of that information.

Mary Hutton
Accountable Officer

3 June 2014

Remuneration Report

Remuneration Report For NHS Gloucestershire CCG								
								2013-14
Name and Title	Start Date	End Date	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to the nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £2,500)	All Pension Related Benefits (bands of £2,500)	Total (bands of £5,000)
Dr Helen Miller, Clinical Chair	1/4/2013	31/03/2014	85-90					85-90
Dr Andy Seymour, Deputy Clinical Chair	1/4/2013	31/03/2014	75-80					75-80
Mary Hutton, Accountable Officer	1/4/2013	31/03/2014	135-140					135-140
Mark Walkingshaw, Deputy Accountable Officer/Director Of Commissioning Implementation	1/4/2013	31/03/2014	105-110					105-110
Cath Leech, Chief Finance Officer	1/4/2013	31/03/2014	105-110					105-110
Jonathan Jeanes, Director Of Transformation and Service Redesign	29/07/2013	31/03/2014	70-75					70-75
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	1/4/2013	31/03/2014	40-45					40-45
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	1/4/2013	31/03/2014	20-25					20-25
Dr Malcolm Gerald, Clinical Commissioning Lead (South Cotswolds)	1/4/2013	31/03/2014	40-45					40-45
Dr Martin Gibbs, Clinical Commissioning Lead (Forest of Dean)	1/4/2013	31/03/2014	40-45					40-45
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	1/4/2013	31/03/2014	40-45					40-45
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)*	1/4/2013	31/03/2014	40-45					40-45
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	1/4/2013	31/03/2014	40-45					40-45
Julie Clatworthy, Registered Nurse	1/4/2013	31/03/2014	15-20					15-20
Dr Marion Andrews-Evans – Executive Nurse & Quality Lead	1/4/2013	31/03/2014	95-100					95-100
Alan Elkin, Lay Member, Patient And Public Engagement/Involvement	1/4/2013	31/03/2014	5-10					5-10
Colin Greaves, Lay Member, Governance	1/4/2013	31/03/2014	15-20					15-20
Rob Rees, Lay Member, Patient And Public Engagement/Involvement	10/05/2013	31/03/2014	5-10					5-10
Valerie Webb, Lay Member, Business	1/4/2013	31/03/2014	5-10					5-10
Dr Steve Allder, Secondary Care Clinical Advisor	1/4/2013	31/03/2014	Payment of £24k was made to Dr Allder's host Trust (Plymouth Hospitals NHS Trust)					
Dr Alice Walsh, Interim Director of Public Health at Gloucestershire County Council	1/4/2013	31/03/2014	No payment is received from NHS Gloucestershire CCG					
Margaret Willcox, Director of Adult Social Care at Gloucestershire County Council	1/4/2013	31/03/2014	No payment is received from NHS Gloucestershire CCG					

*Salary include remuneration for Governing Body duties and additional duties as the lead for dementia.

Pay Multiples

The banded remuneration of the highest paid member of the governing body in the CCG in the financial year 2013/14 was £140-145k. This was 4.13 times the median remuneration of the workforce which was £34,530.

In 2013/14, no employees received remuneration in excess of the highest paid member of the governing body.

Pensions Report for NHS Gloucestershire CCG Name and 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 2014 (Bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2014 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Dr Helen Miller, Clinical Chair	15-17.5	45-47.5	15-20	45-50	13	307	294	12
Dr Andy Seymour, Deputy Clinical Chair	5-7.5	20-22.5	5-10	20-25	24	144	120	11
Mary Hutton, Accountable Officer	0-2.5	5-7.5	25-30	85-90	504	566	51	21
Mark Walkingshaw, Deputy Accountable Officer/ Director Of Commissioning Implementation	0-2.5	2.5-5	25-30	80-85	379	424	36	15
Cath Leech, Chief Finance Officer	2.5-5	12.5-15	25-30	85-90	389	490	92	15
Jonathan Jeanes, Director Of Transformation And Service Redesign	7.5-10	25-27.5	10-15	35-40	0	169	114	9
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	7.5-10	25-27.5	5-10	25-30	9	145	135	6
Dr Charles Buckley, Clinical Commissioning Lead (Stroud & Berkeley Vale)	15-17.5	50-52.5	15-20	50-55	24	394	369	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)	5-7.5	20-22.5	10-15	40-45	124	270	143	6
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	10-12.5	32.5-35	10-15	35-40	9	199	190	6
Dr Hein Le Roux, Clinical Commissioning Lead (Stroud & Berkeley Vale)	0-2.5	0-2.5	5-10	15-20	70	74	2	6
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	5-7.5	20-22.5	5-10	25-30	31	124	93	6
Dr Marion Andrews-Evans – Executive Nurse & Quality Lead	Dr Andrews-Evans has opted out of the NHS Pension Scheme							
Dr 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)							

Certain Members do not receive pensionable remuneration therefore there will be no entries in respect of pensions for certain Members.

The pension figures have been supplied by the NHS Pensions Agency and they have not been subject to any actuarial assessment by the CCG.

Where appropriate the pension cost in the above table include costs in relation to employment other than with the CCG but do not include payments in relation to general practice.

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.

Mary Hutton
Accountable Officer

3 June 2014

Remuneration Committee

Details of the membership of the Remuneration Committee can be found in the Governance Statement. All Remuneration Committee members are also members of the CCG's Governing Body. During the year all meetings were quorate.

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 has not yet agreed 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 is shown within the remuneration table on page 40.

As senior management contracts are substantive and not fixed term, there is no 'unexpired term'; all contracts have notice periods of between three and six months.

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.

Off Payroll Engagements

Off-payroll engagements as of 31 March 2014, for more than £220 per day and that last longer than six months are as follows:

	Number
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	-
- for between two and three years at the time of reporting	-
- for between three and four years at the time of reporting	-
- for four or more years at the time of reporting	-
Total number of existing engagements as of 31 March 2014	1

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014	1
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	-
Number for whom assurance has been requested	1
Of which, the number:	
- For whom assurance has been received	1
- For whom assurance has not been received	-
- That have been terminated as a result of assurance not being received	-

Governing Body Profiles

Profiles of Governing Body members are available on the CCG's website at:

http://www.gloucestershireccg.nhs.uk/about-us/the-governing-body/

Details of membership of each sub committee of the Governing Body are given in the Governance Statement.

The Register of Interests is given below:

Name	Role	Relevant Business Interests
Dr Steven Allder	Secondary Care Doctor	• Consultant for Kings Fund
Dr Marion Andrews-Evans	Executive Nurse & Quality Lead	• Director Advancing Care Ltd • Advancing Care Ltd in Wales to support people with long term needs
Dr Caroline Bennett	GP Locality Lead	• Practice is a member of the Gloucestershire GP Provider Organisation • GP Partner Cotswold Medical Practice inc dispensing medication • Husband is a consultant Anaesthetist at Gloucestershire Hospitals NHS FoundationTrust (GHNHSFT) and private practice (Gloucestershire Anaesthetic Services LLP). Also is involved in medical research
Dr Charles Buckley	GP Locality Lead	• GP partnership, the Surgery, Frampton on Severn, inc dispensing medication • Practice is a member of the Gloucestershire GP Provider Organisation • Attends various post graduate education and development meetings sometimes sponsored by Pharmaceutical companies • Pharmaceutical companies provide a range of educational and supportive materials and services for clinicians and patients free of charge • Trustee in 2 local charities Pinching Memorial Trust and John Buckley Memorial Trust
Julie Clatworthy	Registered Nurse	• Director – Think Ahead in Health Care Ltd • Shareholder in Think Ahead in Health Care Ltd • Standing member of Quality Standards Advisory Committee at NICE (appointed 2012) Member of the RCN
Alan Elkin	Lay Member	Nothing to declare
Dr Malcolm Gerald	GP Locality Lead	• Senior Partner Romney House Surgery Tetbury • Practice is a member of the Gloucestershire GP Provider Organisation • Member of the Medical Advisory Committee for Tetbury Hospital (a quality group only) • Tetbury Hospital Trust – local community hospital charitable trust
Dr Martin Gibbs	GP Locality Lead	• Partner in Forest of Dean Complimentary and Medical Services (currently dormant) • Practice is a member of the Gloucestershire GP Provider Organisation • Employed by Poplars Resettlement Limited, a company caring for those with learning disability • Partner in Blakeney Surgery. Practice holds Community Hospital contract with Gloucestershire Care Services for in-patient care at Dilke and Lydney Hospitals. Blakeney Surgery is a member of the Primary Care Research Network • Paid to chair and to speak at meetings sponsored by various pharmaceutical companies where main purpose of meeting is the improvement of NHS services
Colin Greaves	Lay Member – Governance	• Audit Committee member to the Office of the Police and Crime Commissioner and the Gloucestershire Constabulary • Chair of the Arts in Rural Gloucestershire (arts based charity)
Dr Will Haynes	GP Locality Lead	• GP partnership, Hadwen Medical Practice inc. dispensing medication • Practice is a member of the Gloucestershire GP Provider Organisation • Attends various post graduate education and development meetings sometimes sponsored by Pharmaceutical companies • Wife is a Consultant Breast Surgeon at Gloucestershire Acute Hospital Foundation Trust

Mary Hutton	Accountable Officer	Nothing to declare
Jonathan Jeanes	interim Director of Transformation & Service Redesign	Managing Director of Jeanes Consulting Ltd
Cath Leech	Chief Finance Officer	Nothing to declare
Dr Hein Le Roux	GP Locality Lead	• GP in Minchinhampton Surgery – Diabetes Lead & Commissioning Lead • Wife is a Retainer at Orchard Medical Centre, Cam • GGPET Board Member • Practice is a member of the Gloucestershire GP Provider Organisation • Out of Hours for SWAST
Dr Helen Miller	Clinical Chair	• Partner in GMS Practice, The College Yard and Highnam Surgeries • Practice is a member of the Gloucestershire GP Provider Organisation • Practice provides cover over and above GMS contract with The Dean Neurological Rehabilitation Centre Gloucester (Ramsay Health Care)
Rob Rees	Lay Member	• Director Children's Food Trust/Rob Rees CIC/ Raging Chef Ltd/ Cotswold Chef Ltd • Chief Executive of The Wiggly Worm
Dr Andy Seymour	Deputy Clinical Chair	• Full Time partner in Heathville Medical Practice • Practice is a member of the Gloucestershire GP Provider Organisation
Mark Walkingshaw	Director of Commissioning Implementation	Nothing to declare
Dr Alice Walsh	Interim Director of Public Health Gloucestershire County Council	Nothing to declare
Valerie Webb	Lay Member – Business	• Magistrate duties in Adult Criminal & Family Courts in Gloucestershire
Dr Jeremy Welch	GP Locality Lead	• GP Partner – Jesmond House Practice Tewkesbury • Practice is a member of the Gloucestershire GP Provider Organisation • Locum Out of Hours GP
Margaret Willcox	Director of Adult Social Care Gloucestershire County Council (GCC)	Nothing to declare

Premises

The CCG operates from Sanger House

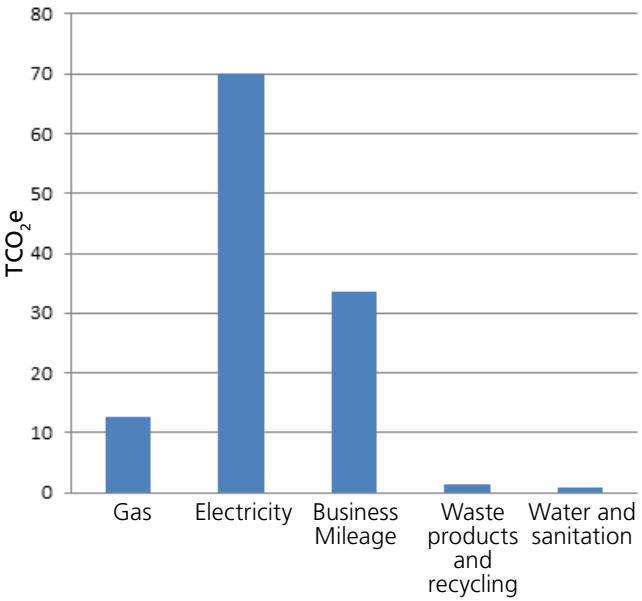
NHS Gloucestershire CCG
Sanger House
5220 Valiant Court
Gloucester Business Park
Brockworth, Gloucester
GL3 4FE

Sustainability Report

Commissioning and procurement account for three-quarters of the carbon footprint of the NHS. As such NHS Gloucestershire Clinical Commissioning Group (GCCG) has a significant role in ensuring that commissioned services contribute to a healthier environment.

GCCG recognises that keeping people healthy and reducing the need to travel to hospital is essential for the delivery of sustainable healthcare. The delivery of care in the patient's own home and in the community has therefore been a priority this year.

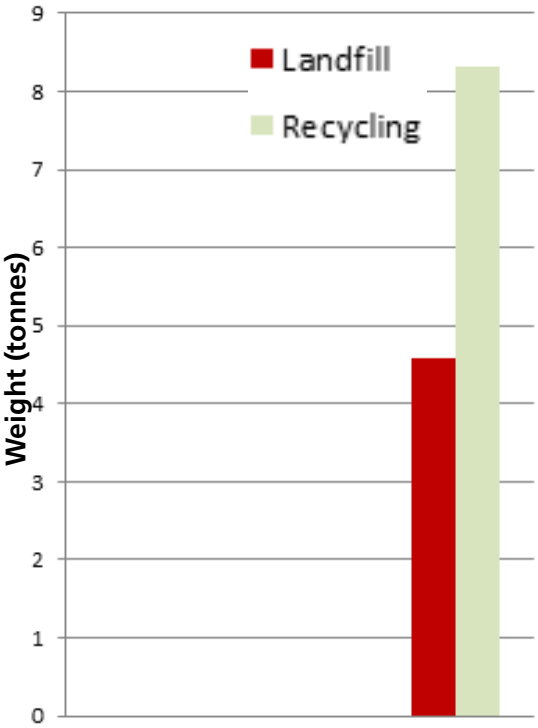
Carbon emissions from buildings and travel



Telecare has continued to be rolled out in Gloucestershire to support this and further investment has been made in Primary Care and Integrated Community Teams.

The high carbon footprint of wasted medicines has been made clear in the national NHS Sustainability Strategy. GCCG has considered how it can influence this and has promoted an inhaler recycling scheme with local pharmacies. Workshops have also been run on the correct use of inhalers to ensure that the pharmaceuticals (and associated gas and packaging) delivers the optimum benefit for the patient.

Waste Breakdown 2013/14



GCCG has been able to use its role as lead health commissioner for Gloucestershire to encourage and ensure that our providers are working on sustainable development plans and can demonstrate real change as a result. Our main providers have been able to do this

GCCG led on sustainability in the South West Non-Emergency patient transport (NEPT) procurement and were able to ensure that the vehicles used by the provider will deliver the lowest emissions through vehicle design, telemetry and route planning.

GCCG works out of Sanger House, Gloucester Business Park which is a building shared with other organisations.

It is assumed that GCCG are responsible for half of the use of natural resources since we occupy half of the space. Provisional energy data shows an increase in energy and water use from the building which will be corrected.

Goods and Services Spend Profile	Kg CO2e
Food and catering	2.81623
Information and communication technologies	173.0893
Paper products	23.881
Pharmaceuticals	30937.99
Travel	102.321
Commissioning	912006.9

NHS Gloucestershire CCG 2013 - 14 Annual Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	£000
Administration Costs and Programme Expenditure	
Gross employee benefits	6,397
Other costs	683,442
Other operating revenue	(17,754)
Net operating costs before interest	672,084
Investment revenue	-
Other (gains)/losses	-
Finance costs	-
Net operating costs for the financial year	672,084
Net (gain)/loss on transfers by absorption	
Net operating costs for the financial year including absorption transfers	672,084
Of which:	
Administration Costs	
Gross employee benefits	5,385
Other costs	9,183
Other operating revenue	(427)
Net administration costs before interest	14,142
Programme Expenditure	
Gross employee benefits	1,011
Other costs	674,258
Other operating revenue	(17,327)
Net programme expenditure before interest	657,942
Other Comprehensive Net Expenditure	
	£000
Impairments and reversals	-
Net gain/(loss) on revaluation of property, plant & equipment	-
Net gain/(loss) on revaluation of intangibles	-
Net gain/(loss) on revaluation of financial assets	-
Movements in other reserves	-
Net gain/(loss) on available for sale financial assets	-
Net gain/(loss) on assets held for sale	-
Net actuarial gain/(loss) on pension schemes	-
Share of (profit)/loss of associates and joint ventures	-
Reclassification Adjustments	
On disposal of available for sale financial assets	-
Total comprehensive net expenditure for the year	672,084

Statement of Financial Position as at 31 March 2014

	£000
Non-current assets:	
Property, plant and equipment	61
Intangible assets	-
Investment property	-
Trade and other receivables	-
Other financial assets	-
Total non-current assets	**61**
Current assets:	
Inventories	-
Trade and other receivables	8,350
Other financial assets	-
Other current assets	-
Cash and cash equivalents	30
Total current assets	**8,380**
Non-current assets held for sale	**-**
Total current assets	**8,380**
Total assets	**8,441**
Current liabilities	
Trade and other payables	42,948
Other financial liabilities	-
Other liabilities	-
Borrowings	-
Provisions	870
Total current liabilities	**43,819**
Total Assets less Current Liabilities	**(35,378)**
Non-current liabilities	
Trade and other payables	-
Other financial liabilities	-
Other liabilities	-
Borrowings	-
Provisions	-
Total non-current liabilities	**-**
Total Assets Employed	**(35,378)**
Financed by Taxpayers' Equity	
General fund	(35,378)
Revaluation reserve	-
Other reserves	-
Charitable Reserves	-
Total taxpayers' equity:	**(35,378)**

The financial statements were approved by the Governing Body on 3 June 2014 and signed on its behalf by:

Accountable Officer
Mary Hutton

Statement of Changes In Taxpayers Equity for the year ended	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	-	-	-	-
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	586	-	-	586
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted CCG balance at 1 April 2013	**586**	**-**	**-**	**586**
Changes in CCG taxpayers' equity for 2013-14				
Net operating costs for the financial year	(672,084)	-	-	(672,084)
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Transfer between reserves in respect of assets transferred under absorption	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised CCG Expenditure for the Financial Year	**(671,498)**	**-**	**-**	**(671,498)**
Net funding	636,120	-	-	636,120
Balance at 31 March 2014	**(35,378)**	**-**	**-**	**(35,378)**

Statement of Cash Flows for the year ended 31 March 2014

	£000
Cash Flows from Operating Activities	
Net operating costs for the financial year	(672,084)
Depreciation and amortisation	525
Impairments and reversals	-
Other gains (losses) on foreign exchange	-
Donated assets received credited to revenue but non-cash	-
Government granted assets received credited to revenue but non-cash	-
Interest paid	-
Release of PFI deferred credit	-
(Increase)/decrease in inventories	-
(Increase)/decrease in trade & other receivables	(8,350)
(Increase)/decrease in other current assets	-
Increase/(decrease) in trade & other payables	42,948
Increase/(decrease) in other current liabilities	-
Provisions utilised	-
Increase/(decrease) in provisions	870
Net Cash Inflow (Outflow) from Operating Activities	**(636,090)**
Cash Flows from Investing Activities	
Interest received	-
(Payments) for property, plant and equipment	-
(Payments) for intangible assets	-
(Payments) for investments with the Department of Health	-
(Payments) for other financial assets	-
(Payments) for financial assets (LIFT)	-
Proceeds from disposal of assets held for sale: property, plant and equipment	-
Proceeds from disposal of assets held for sale: intangible assets	-
Proceeds from disposal of investments with the Department of Health	-
Proceeds from disposal of other financial assets	-
Proceeds from disposal of financial assets (LIFT)	-
Loans made in respect of LIFT	-
Loans repaid in respect of LIFT	-
Rental revenue	-
Net Cash Inflow (Outflow) from Investing Activities	**-**
Net Cash Inflow (Outflow) before Financing	**(636,090)**
Cash Flows from Financing Activities	
Net funding received	636,120
Other loans received	-
Other loans repaid	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	-
Capital grants and other capital receipts	-
Capital receipts surrendered	-
Net Cash Inflow (Outflow) from Financing Activities	**636,120**
Net Increase (Decrease) in Cash & Cash Equivalents	**30**
Cash & Cash Equivalents at the Beginning of the Financial Year	**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**30**

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	Target	Performance	Met (Y/N)?
			£000	£000	
Expenditure not to exceed income (i.e. to report surplus)	1	223H (1)	6,757	6,806	Yes
Capital resource use does not exceed the amount specified in Directions	2	223I (2)	Nil	Nil	Yes
Revenue resource use does not exceed the amount specified in Directions	1	223I (3)	678,890	672,084	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	2	223J (1)	Nil	Nil	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	3	223J (2)	Nil	Nil	Yes
Revenue administration resource use does not exceed the amount specified in Directions	4	223J (3)	15,090	14,142	Yes

1. Performance against Revenue Resource limit

	£000	£000
From Statement of Comprehensive Net Expenditure		
Net operating cost for the financial year	672,084	
Net gain/(loss) on transfers by absorption	Nil	
		672,084
Revenue Resource Limit		678,890
Under/(Over) spend against Revenue Resource Limit (RRL)		6,806

2. Performance against Capital Resource limit

The CCG did not receive a Capital Resource Limit in 2013/14 and has not committed to any capital expenditure during the period.

3. Revenue resource use on specified matters

The CCG did not receive any Revenue Resource Limit in 2013/14 to use on specified matters.

4. Performance against Revenue administration resource

	£000	£000
From Statement of Comprehensive Net Expenditure		
Gross employee benefits	5,385	
Other costs	9,183	
Other operating revenue	(427)	
		14,142
Revenue administration resource ("running costs" allocation)		15,090
Under/(Over) spend against Revenue administration resource		948

Summary Financial Statements

The summary financial statements show the financial position of the Clinical Commissioning Group for the financial year 2013/14. They are a summary of the information in the full accounts which are available on request from the

Chief Financial Officer,
NHS Gloucestershire CCG,
Sanger House,
5220 Valiant Way,
Gloucester Business Park,
Brockworth,
Gloucester.
GL3 4FE.

Statement of the responsibilities of the Accountable Officer of 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; and,
- Prepare the financial statements on a going concern basis.

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

Mary Hutton

Accountable Officer

3 June 2014

Governance Statement

Introduction and Context

The Clinical Commissioning Group 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.

The Clinical Commissioning Group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the Clinical Commissioning Group taking on its full powers.

As at 1 April 2013, the Clinical Commissioning Group was licensed without conditions.

Scope of Responsibility

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

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

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.

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 Integrated Governance Committee, which reports to the Governing Body, is responsible for monitoring the governance arrangements for the Clinical Commissioning Group.

The Constitution of the Clinical Commissioning Group (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 interest is reviewed regularly, and updated as necessary; and

e. ensures that all conflicts of interest or potential conflicts of interest are declared.

The Governing Body comprises the following members:

CCG Chair (Dr Helen Miller)

Deputy Clinical Chair (Dr Andy Seymour)

GP Member (Dr Caroline Bennett)

GP Member (Dr Charles Buckley)

GP Member (Dr Malcolm Gerald)

GP Member (Dr Martin Gibbs)

GP Member (Dr Will Haynes)

GP Member (Dr Hein Le Roux)

GP Member (Dr Jeremy Welch)

Accountable Officer (Mary Hutton)

Chief Finance Officer (Cath Leech)

Director of Public Health Dr (Alice Walsh)

Director of Adult Social Care (Margaret Willcox)

Registered Nurse (Julie Clatworthy)

Secondary Care Specialist (Dr Steve Allder)

Lay Member – Governance (Colin Greaves)

Lay Member – Business (Valerie Webb)

Lay Member – PPE (Rob Rees)

Vice Chair and Lay Member – PPE (Alan Elkin)

Executive Nurse and Quality Lead (Dr Marion Andrews-Evans)

Director of Commissioning Implementation (Mark Walkingshaw)

Director of Transformation and Service Redesign (Jonathan Jeanes)

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 three committees:

- Audit Committee
- Remuneration Committee
- Integrated Governance Committee.

A self-assessment of the organisation, including an analysis of the performance of the Governing Body, was undertaken in December 2013. This review considered the degree of compliance with the Draft Framework of Excellence in Clinical Commissioning, published by NHS England. The conclusion of this review was that there was a good level of compliance with the Framework principles and that the organisation was generally operating well. A small number of areas were identified where performance could be improved and an action plan to address these was formulated and included in the CCG's work programme.

The Audit Committee provides the Governing Body with an independent and objective view of the CCG's financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance.

The Audit Committee comprises the following members:

Lay Member – Governance and Audit Committee Chair (Colin Greaves)

Deputy Clinical Chair (Dr Andy Seymour)

GP Member (Dr Hein Le Roux)

Lay Member – Business (Valerie Webb)

Vice Chair and Lay Member – PPE (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 makes recommendations to the Governing Body regarding the remuneration, fees and other allowances for employees and for people who provide services to the CCG 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 – PPE and Remuneration Committee Chair (Alan Elkin)

CCG Chair (Dr Helen Miller)

Deputy Clinical Chair (Dr Andy Seymour)

GP Member (Dr Jeremy Welch)

Lay Member – Governance (Colin Greaves)

Lay Member – Business (Valerie Webb)

Lay Member – PPE (Rob Rees)

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 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, financial 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 Committee comprises the following members:

Registered Nurse and IGC Chair (Julie Clatworthy)

CCG Chair (Dr Helen Miller)

GP Member (Dr Caroline Bennett)

GP Member (Dr Charles Buckley)

GP Member (Dr Malcolm Gerald)

GP Member (Dr Martin Gibbs)

Accountable Officer (Mary Hutton)

Chief Finance Officer (Cath Leech)

Director of Public Health (Dr Alice Walsh)

Secondary Care Specialist (Dr Steve Allder)

Lay Member- Governance (Colin Greaves)

Lay Member – Business (Valerie Webb)

Vice Chair and Lay Member – PPE (Alan Elkin)

Executive Nurse and Quality Lead (Dr Marion Andrews-Evans)

Director of Commissioning Implementation and Deputy Accountable Officer (Mark Walkingshaw)

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

The Clinical Commissioning Group Risk Management Framework

The risk and control framework is outlined in the CCG'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 form the Corporate Risk Register. The management of identified risks are the responsibility of nominated managers. The Corporate Risk Register is presented to the bi-monthly meetings of the Integrated Governance Committee, where the acceptability of the risk and the adequacy of the action plans are considered.

The more significant risks are also included in the Assurance Framework which is presented regularly to meetings of both the Integrated Governance 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 CCG's Annual Objectives.

Information risk management is integrated with the CCG's 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, Central Southern CSU and Countywide IT Services, the CCG 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.

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

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 CCG and is considered as an integral part of the organisation's activities.

An ethical framework has been developed to support the CCG decision making process and a Priorities Committee has been established as a sub-committee of the Integrated Governance Committee. The purpose of the Priorities Committee is to underpin the decision making process of the CCG and contributes to achieving a consistent approach to commissioning. All service change proposals are subject to equalities 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 CCG operates an electronic incident reporting system. All staff and members of the CCG are encouraged to report incidents in order that learning can be shared and risks of re-occurrence minimised. The incident reporting system is promoted through the CCG's intranet.

The CCG is regularly in contact with over 1200 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.

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.

Information Governance

All risk relating to data security are managed in accordance with the Risk Management Policy and are entered onto the CCG Risk Register which is presented to each meeting of the Integrated Governance Committee. The Committee reviews all risks and monitors the progress of action plans.

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

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing 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.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, Diversity & Human Rights Obligations

Control measures are in place to ensure that the Clinical Commissioning Group complies with the required public sector equality duty set out in the Equality Act 2010.

Sustainable Development Obligations

The Clinical Commissioning Group has undertaken risk assessments and Carbon Reduction Delivery Plans are in place within provider organisations in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this clinical commissioning group's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

We are also setting out our commitments as a socially responsible employer.

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

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 CCG managers. Summarised details of these are given below:

- changes to allocations through the finalisation of baselines to new commissioning organisations were not cost neutral, particularly in relation to specialist commissioning. This risk, which was identified at the beginning of the financial year, was mitigated through on-going work with specialist and other commissioning organisations where the impact of the changes were addressed
- two risks were identified in relation to the launch of the NHS111 service. These risks related to the possibility of the full public launch being delayed and the anticipated whole system benefits not being achieved. A rectification plan was actioned which resulted in the full launch going ahead in October 2013. An action plan to ensure that benefits are provided is being progressed
- patient information required to support service transformation was limited or unavailable due to changes in legislation and uncertainty over access arrangements. Section 251 of the Health and Social Care Act 2001(which allows the Secretary of State for Health to make regulations to set aside the common law duty of confidentiality for defined medical purposes) is now in place for all national data flows. The risk has been further reduced by refinement of local data flows and the channeling of all patient identifiable data through an accredited data warehouse
- a short-term risk was identified in relation to the provision of non-emergency patient transport services. Concerns were identified regarding the ability of existing provider to continue the service prior to the commencement of a new contract. This risk was addressed by way of a negotiated agreement to continue service provision with the existing provider
- incidence of MRSA and C. Difficile within the provider trusts placed the CCG's ability to comply with national targets at risk. As the incidents reported to date have resulted in some targets not being met, this risk remained 'high' at the year end. A Health Care Acquired Infections Action Plan has been developed and is being implemented.

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.

A total of 18 confidentiality incidents have been reported in relation to the CCG over the year. Of these, three were graded as moderate, twelve as low, and four as very low. None of these were reportable to the Information Commissioner, resulted in any impact on a patient or resulted in the disclosure of sensitive information outside of an NHS setting. The incidents all related to unsecured documents in the CCG HQ, the offices of which are secure, or to email being sent across potentially insecure domains. This provides assurance that specific systems for information exchange are well governed and secure.

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

The CCG'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 review of the 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's compliance against the organisational objectives and financial targets.

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. The Corporate Risk Register is presented to the bi-monthly meetings of the Integrated Governance Committee where the adequacy of the risk assessments are considered. The more significant risks are also included in the Assurance Framework which is presented regularly to meetings of both the Integrated Governance 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 management letter and other reports.

The *Board Assurance Framework* itself 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 Integrated Governance Committee, if appropriate and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Appended to the CCG 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 CCG 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, which is accountable to the Group's Governing Body, 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.

Internal Audit undertook a risk management and governance review during the year. The final report, issued in January 2014, identified just one low-risk finding.

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:

Our opinion is based solely on work we have completed to assess whether the controls in place support the achievement of management's objectives as set out in our Individual Assignment Reports, but our opinion does not take into account the results of any internal audit or other assurance work conducted in relation to the Commissioning Support Unit or other service organisations.

We have completed the programme of internal audit work for the year ended 31 March 2014. Our work identified low, medium and high rated findings. Based on the work we have completed, we believe that there is some risk that management's objectives may not be fully achieved. Improvements are required in those areas to enhance the adequacy and/or effectiveness of governance, risk management and control.

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

- the overall classification of the Commissioning Support Unit (CSU) contract monitoring and reporting report was high risk. This report included two high risk findings and two medium risk findings
- we identified one high risk finding in our review of Service Level Agreements – performance, which related to a number of unsigned contracts inherited from the PCT
- we identified one high risk finding in our review of Information Governance arrangements, which related to the CCG's overall progress against the requirements of the Information Governance Toolkit.

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

The Commissioning Support Unit – Contract Monitoring and Performance audit resulted in a high risk classification. Included in this report were two high risk findings relating to service line specifications and that CSU reward is not linked to performance. The following action plans were agreed by CCG managers to address these issues:

- the CCG Service Leads will perform an exercise which clearly defines the services required by the CCG in each area. These requirements could be categorised between those which comprise the core service required and those which are supplementary/added value
- the CCG will agree with the CSU what requirements they can/should provide as per the contract
- the contract appendices will be amended accordingly to reflect the rewritten Service Line Specifications
- the CCG and CSU will agree a schedule of financial consequences for the failure to meet certain key Service Line Specifications
- there should be a clear link between the CCG requirement, the CSU Service Line Specifications, the KPI/ performance standard detailing success or failure, and the financial consequence.

Additional reward could also be offered for meeting stretch targets or delivering an exceptional quality of service.

Data Quality

A detailed performance report is presented to each bi-monthly meeting of the Governing Body.

Business Critical Models

The CCG is currently in the process of identifying any business critical models; this is due to be completed by the end of May 2014. The CCG has internal processes to ensure that all internally developed models have quality assurance processes that are proportionate to the risk to the organisation.

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

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were 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 clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

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

Conclusion

No significant internal control issues have been identified during 2013/14.

Mary Hutton
Accountable Officer

3 June 2014

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

We have audited the financial statements of Gloucestershire Clinical Commissioning Group for the year ended 31 March 2014 under the Audit Commission Act 1998. 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 the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

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

- the table of salaries and allowances of senior managers and related narrative notes on page 40
- the table of pension benefits of senior managers and related narrative notes on page 41
- the pay multiples note on page 40

This report is made solely to the members of Gloucestershire Clinical Commissioning Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)'s members and the CCG as a body, for our audit work, for this report, or for 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. 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 also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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 CCG; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report which comprises the Member Practices' Introduction, Strategic Review, Governing Body Report, Remuneration Report, Statement of the responsibilities of the Accountable Officer, summarised financial statements and the Governance Statement 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 reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the financial position of Gloucestershire Clinical Commissioning Group as at 31 March 2014 and of its net operating costs for the year then ended; and

- have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion:

- the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State; and
- the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we report by exception

We report to you if:

- in our opinion the governance statement does not reflect compliance with NHS England's Guidance;
- we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement;
- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and
- locally determined risk-based work on the arrangements in place to implement the Better Care Fund.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of Gloucestershire Commissioning Group in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Elizabeth A Cave
Director for and on behalf of Grant Thornton UK LLP, Appointed Auditor
Grant Thornton UK LLP
Hartwell House, 55-61 Victoria Street,
Bristol BS1 6FT

4 June 2014

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Data entered below will be used throughout the workbook:

Entity name:	NHS GLOUCESTERSHIRE CCG
This year	2013-14
This year ended	31 March 2014
This year commencing:	1 April 2013

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Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	6	6,397
Other costs	5	683,442
Other operating revenue	3	(17,754)
Net operating costs before interest		672,084
Investment revenue	9	-
Other (gains)/losses	10	-
Finance costs	11	-
Net operating costs for the financial year		672,084
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		672,084
Of which:		
Administration Costs		
Gross employee benefits	6	5,385
Other costs	5	9,183
Other operating revenue	3	(427)
Net administration costs before interest		14,142
Programme Expenditure		
Gross employee benefits	6	1,011
Other costs	5	674,258
Other operating revenue	3	(17,327)
Net programme expenditure before interest		657,942

Other Comprehensive Net Expenditure		2013-14 £000
Impairments and reversals	23	-
Net gain/(loss) on revaluation of property, plant & equipment		-
Net gain/(loss) on revaluation of intangibles		-
Net gain/(loss) on revaluation of financial assets		-
Movements in other reserves		-
Net gain/(loss) on available for sale financial assets		-
Net gain/(loss) on assets held for sale		-
Net actuarial gain/(loss) on pension schemes		-
Share of (profit)/loss of associates and joint ventures		-
Reclassification Adjustments		
On disposal of available for sale financial assets		-
Total comprehensive net expenditure for the year		672,084

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment	14	61
Intangible assets	15	-
Investment property	16	-
Trade and other receivables	18	-
Other financial assets	19	-
Total non-current assets		61
Current assets:		
Inventories	17	-
Trade and other receivables	18	8,350
Other financial assets	19	-
Other current assets	20	-
Cash and cash equivalents	21	30
Total current assets		8,380
Non-current assets held for sale	22	-
Total current assets		8,380
Total assets		8,441
Current liabilities		
Trade and other payables	24	42,948
Other financial liabilities	25	-
Other liabilities	26	-
Borrowings	27	-
Provisions	31	870
Total current liabilities		43,819
Total Assets less Current Liabilities		(35,378)
Non-current liabilities		
Trade and other payables	24	-
Other financial liabilities	25	-
Other liabilities	26	-
Borrowings	27	-
Provisions	31	-
Total non-current liabilities		-
Total Assets Employed		(35,378)
Financed by Taxpayers' Equity		
General fund		(35,378)
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		(35,378)

The notes on pages 5 to 35 form part of this statement

The financial statements on pages 1 to 4 were approved by the Governing Body on 3 June 2014 and signed on its behalf by:

Mary Hutton

Accountable Officer
Mary Hutton

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	General fund	Revaluation reserve	Other reserves	Total reserves
	£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14				
Balance at 1 April 2013	-	-	-	-
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition	586	-	-	586
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted CCG balance at 1 April 2013	**586**	**-**	**-**	**586**
Changes in CCG taxpayers' equity for 2013-14				
Net operating costs for the financial year	(672,084)	-	-	**(672,084)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total revaluations against revaluation reserve	**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Transfer between reserves in respect of assets transferred under absorption	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised CCG Expenditure for the Financial Year	(671,498)	-	-	**(671,498)**
Net funding	636,120	-	-	**636,120**
Balance at 31 March 2014	**(35,378)**	**-**	**-**	**(35,378)**

Statement of Cash Flows for the year ended 31 March 2014

	2013-14 £000
Cash Flows from Operating Activities	
Net operating costs for the financial year	(672,084)
Depreciation and amortisation	525
Impairments and reversals	-
Other gains (losses) on foreign exchange	-
Donated assets received credited to revenue but non-cash	-
Government granted assets received credited to revenue but non-cash	-
Interest paid	-
Release of PFI deferred credit	-
(Increase)/decrease in inventories	-
(Increase)/decrease in trade & other receivables	(8,350)
(Increase)/decrease in other current assets	-
Increase/(decrease) in trade & other payables	42,948
Increase/(decrease) in other current liabilities	-
Provisions utilised	-
Increase/(decrease) in provisions	870
Net Cash Inflow (Outflow) from Operating Activities	(636,090)
Cash Flows from Investing Activities	
Interest received	-
(Payments) for property, plant and equipment	-
(Payments) for intangible assets	-
(Payments) for investments with the Department of Health	-
(Payments) for other financial assets	-
(Payments) for financial assets (LIFT)	-
Proceeds from disposal of assets held for sale: property, plant and equipment	-
Proceeds from disposal of assets held for sale: intangible assets	-
Proceeds from disposal of investments with the Department of Health	-
Proceeds from disposal of other financial assets	-
Proceeds from disposal of financial assets (LIFT)	-
Loans made in respect of LIFT	-
Loans repaid in respect of LIFT	-
Rental revenue	-
Net Cash Inflow (Outflow) from Investing Activities	-
Net Cash Inflow (Outflow) before Financing	(636,090)
Cash Flows from Financing Activities	
Net funding received	636,120
Other loans received	-
Other loans repaid	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT	-
Capital grants and other capital receipts	-
Capital receipts surrendered	-
Net Cash Inflow (Outflow) from Financing Activities	636,120
Net Increase (Decrease) in Cash & Cash Equivalents	30
Cash & Cash Equivalents at the Beginning of the Financial Year	-
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	30

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 2013-14* 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.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Acquisitions & Discontinued Operations

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

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.
Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

In accordance with the Health and Social Care Act 2012, Strategic Health Authorities and Primary Care Trusts were dissolved on 1 April 2013 and their assets and liabilities transferred to successor bodies in the NHS or to other entities. Under the terms of the Property Transfer Scheme and its supporting schedules, a number of assets and liabilities were transferred from Gloucestershire Primary Care Trust to the CCG on that date. The most significant of these was regarding IT equipment.

These assets and liabilities are associated with the transfer of commissioning functions.

The accounting arrangements in respect of these transfers are outlined in Note 1.3 to the Annual Accounts.

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 12 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 31 to these financial statements."

Notes to the financial statements

1.5 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

The CCG does not hold any Charitable Funds.

1.6 Pooled Budgets

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

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 Critical Judgements in Applying Accounting Policies

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

- 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).

Notes to the financial statements

1.7.2 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 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.

- Valuation assumptions for property, plant and equipment
The valuation of IM & T assets has been assessed using an independent source.

- Provisions recognised as at 31st March 2014
The provision for continuing healthcare has been calculated by taking those claims outstanding at 31 March 2014 which had not previously been notified to NHS England. An assessment of the likely financial value is then made and a conversion rate applied (based on previous claim 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 monitoring 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 estimated 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.

1.8 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.
Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.9 Employee Benefits

1.9.1 Short-term Employee Benefits

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

1.9.2 Retirement Benefit Costs

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

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

1.10 Other Expenses

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

1.11 Property, Plant & Equipment

1.11.1 Recognition

Property, plant and equipment is capitalised if:

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

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.

1.11.2 Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.
Land and buildings used for the clinical commissioning group's services or for administrative purposes are stated in the statement of financial position at their re-valued amounts, being the fair value at the date of revaluation less any impairment.
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 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.

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.
Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.13 Depreciation, Amortisation & Impairments

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

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

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

Notes to the financial statements

1.14 Donated Assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.15 Government Grants

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

1.16 Non-current Assets Held For Sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Net Expenditure. On disposal, the balance for the asset on the revaluation reserve is transferred to the general reserve.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

1.18.1 Services Received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

1.18.2 PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the clinical commissioning group's approach for each relevant class of asset in accordance with the principles of IAS 16.
NHS Gloucestershire CCG does not hold any PFI assets.

1.18.3 PFI Liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.
An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'finance costs' within the Statement of Comprehensive Net Expenditure.
The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Net Expenditure.

Notes to the financial statements

1.18.4 Lifecycle Replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the clinical commissioning group's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

1.18.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the clinical commissioning group's Statement of Financial Position.

1.18.6 Other Assets Contributed by the Clinical Commissioning Group to the Operator

Assets contributed (e.g. cash payments, surplus property) by the clinical commissioning group to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the clinical commissioning group, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.
NHS Gloucestershire CCG has no assets falling into such a relationship.

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.20 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

Notes to the financial statements

1.21 Provisions

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when the clinical commissioning group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

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

1.24 Carbon Reduction Commitment Scheme

Carbon Reduction Commitment and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the clinical commissioning group makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.25 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.

Notes to the financial statements

1.26 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

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

1.26.1 Financial Assets 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 assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the clinical commissioning group's surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

1.26.2 Held to Maturity Assets

Held to maturity investments are non-derivative financial assets with fixed or determinable payments and fixed maturity, and there is a positive intention and ability to hold to maturity. After initial recognition, they are held at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

1.26.3 Available For Sale Financial Assets

Available for sale financial assets are non-derivative financial assets that are designated as available for sale or that do not fall within any of the other three financial asset classifications. They are measured at fair value with changes in value taken to the revaluation reserve, with the exception of impairment losses. Accumulated gains or losses are recycled to surplus/deficit on de-recognition.

1.26.4 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.
Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.
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.

1.27 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.

1.27.1 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.

1.27.2 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.

1.27.3 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.

1.28 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.

Notes to the financial statements

1.29 Foreign Currencies
The clinical commissioning group's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.30 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.

1.31 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).

1.32 Subsidiaries
Material entities over which the clinical commissioning group has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the clinical commissioning group or where the subsidiary's accounting date is not co-terminus.
Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.
The CCG does not have any subsidiaries.

1.33 Associates
Material entities over which the clinical commissioning group has the power to exercise significant influence so as to obtain economic or other benefits are classified as associates and are recognised in the clinical commissioning group's accounts using the equity method. The investment is recognised initially at cost and is adjusted subsequently to reflect the clinical commissioning group's share of the entity's profit/loss and other gains/losses. It is also reduced when any distribution is received by the clinical commissioning group from the entity.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.
The CCG does not have any associates.

Notes to the financial statements

1.34 Joint Ventures

Material entities over which the clinical commissioning group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.
Joint ventures that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.
The CCG does not have any joint ventures.

1.35 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.
The CCG does not have any joint operations.

1.36 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.

1.37 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 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

2. 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	2013-14 Target £000	2013-14 Performance £000	Met (Y/N)?
Expenditure not to exceed income (i.e. to report surplus)	2.1	223H (1)	6,757	6,806	Yes
Capital resource use does not exceed the amount specified in Directions	2.2	223I (2)	Nil	Nil	Yes
Revenue resource use does not exceed the amount specified in Directions	2.1	223I (3)	678,890	672,084	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	2.2	223J (1)	Nil	Nil	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions (e.g. capital grants)	2.3	223J (2)	Nil	Nil	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2.4	223J (3)	15,090	14,142	Yes

2.1 Performance against Revenue Resource limit

	£000	£000
From Statement of Comprehensive Net Expenditure (page 1)		
Net operating cost for the financial year	672,084	
Net gain/(loss) on transfers by absorption	0	
		672,084
Revenue Resource Limit		678,890
Under/(Over) spend against Revenue Resource Limit (RRL)		6,806

2.2 Performance against Capital Resource limit

The CCG did not receive a Capital Resource Limit in 2013/14 and has not committed to any capital expenditure during the period.

2.3 Revenue resource use on specified matters

The CCG did not receive any Revenue Resource Limit in 2013/14 for use on specified matters.

2.4 Performance against Revenue administration resource

	£000	£000
From Statement of Comprehensive Net Expenditure (page 1)		
Gross employee benefits	5,385	
Other costs	9,183	
Other operating revenue	(427)	
		14,142
Revenue administration resource ("running costs" allocation)		15,090
Under/(Over) spend against Revenue administration resource		948

3. Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	-	-	-
Patient transport services	-	-	-
Prescription fees and charges	0	-	0
Dental fees and charges	-	-	-
Education, training and research	-	-	-
Charitable and other contributions to revenue expenditure: NHS	-	-	-
Charitable and other contributions to revenue expenditure: non-NHS	24	24	-
Receipt of donations for capital acquisitions: NHS Charity	-	-	-
Receipt of Government grants for capital acquisitions	-	-	-
Non-patient care services to other bodies	17,625	403	17,222
Income generation	-	-	-
Rental revenue from finance leases	-	-	-
Rental revenue from operating leases	-	-	-
Other revenue	106	1	105
Total other operating revenue	17,754	427	17,327

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 account of the CCG and credited to the General Fund.

4. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	5,757	4,745	1,011
Executive governing body members	640	640	-
Total gross employee benefits	**6,397**	**5,385**	**1,011**
Other costs			
Services from other CCGs and NHS England	**4,670**	4,649	21
Services from foundation trusts	**405,055**	66	404,988
Services from other NHS trusts	**101,410**	2	101,408
Services from other NHS bodies	**(186)**	-	(186)
Purchase of healthcare from non-NHS bodies	**64,965**	266	64,698
Chair and lay membership body and governing body members	**639**	639	-
Supplies and services – clinical	**3,105**	-	3,105
Supplies and services – general	**1,577**	209	1,368
Consultancy services	**364**	263	101
Establishment	**876**	515	361
Transport	**23**	23	-
Premises	**1,462**	1,453	9
Impairments and reversals of receivables	**61**	61	-
Inventories written down	-	-	-
Depreciation	**525**	525	-
Amortisation	-	-	-
Impairments and reversals of property, plant and equipment	-	-	-
Impairments and reversals of intangible assets	-	-	-
Impairments and reversals of financial assets	-	-	-
· Assets carried at amortised cost	-	-	-
· Assets carried at cost	-	-	-
· Available for sale financial assets	-	-	-
Impairments and reversals of non-current assets held for sale	-	-	-
Impairments and reversals of investment properties	-	-	-
Audit fees	**116**	116	-
Other auditor's remuneration			
· Internal audit services	-	-	-
· Other services	-	-	-
General dental services and personal dental services	-	-	-
Prescribing costs	**87,371**	-	87,371
Pharmaceutical services	-	-	-
General opthalmic services	-	-	-
GPMS/APMS and PCTMS	**4,785**	-	4,785
Other professional fees excl. audit	**622**	215	407
Grants to other public bodies	**4,928**	-	4,928
Clinical negligence	-	-	-
Research and development (excluding staff costs)	-	-	-
Education and training	**133**	109	24
Change in discount rate	-	-	-
Other expenditure	**942**	72	870
Total other costs	**683,442**	9,183	674,258
Total operating expenses	**689,839**	**14,569**	**675,270**

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

6. Employee benefits and staff numbers

6.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	5,313	4,990	323	4,462	4,220	242	851	770	81
Social security costs	435	435	-	376	376	-	59	59	-
Employer Contributions to NHS Pension scheme	645	645	-	543	543	-	102	102	-
Other pension costs	-	-	-	-	-	-	-	-	-
Other post-employment benefits	-	-	-	-	-	-	-	-	-
Other employment benefits	-	-	-	-	-	-	-	-	-
Termination benefits	4	4	-	4	4	-	-	-	-
Gross employee benefits expenditure	6,397	6,074	323	5,385	5,144	242	1,011	930	81
Less recoveries in respect of employee benefits (note 6.1.2)	-	-	-	-	-	-	-	-	-
Total - Net admin employee benefits including capitalised costs	6,397	6,074	323	5,385	5,144	242	1,011	930	81
Less: Employee costs capitalised	-	-	-	-	-	-	-	-	-
Net employee benefits excluding capitalised costs	6,397	6,074	323	5,385	5,144	242	1,011	930	81

Employees reported against programme costs solely relate to those staff engaged on Continuing Healthcare duties.

6.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	-	-	-
Social security costs	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	-	-	-

6.2 Average number of people employed

2013-14	Total	Permanently employed	Other
	Number	Number	Number
Total	132	122	10
Of the above:			
Number of whole time equivalent people engaged on capital projects	Nil	Nil	Nil

6.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	786
Total Staff Years	126
Average working Days Lost	6

Average working days lost has been calculated by NHS England and is based on the period April 2013 to December 2013 inclusive.

	2013-14 Number
Number of persons retired early on ill health grounds	Nil
Total additional Pensions liabilities accrued in the year	Nil

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

6.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	3,817	1	3,817
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	-	-	1	3,817	1	3,817

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

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	1	3,817
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	1	3,817

* Includes any non-contractual severance payments made following judicial mediation, and none relating to non-contractual payments in lieu of notice.

6.5 Pension costs

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

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

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

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

6.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of Pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of Pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their Pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

6.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

6.5 Pension costs

6.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

• The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

• With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as "pension commutation";

• Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

• Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

• 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 the statement of comprehensive net expenditure at the time the clinical commissioning group commits itself to the retirement, regardless of the method of payment; and,

• Members can purchase additional service in the Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

7.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	5,291	73,400
Total Non-NHS Trade Invoices paid within target	4,899	71,409
Percentage of Non-NHS Trade invoices paid within target	92.59%	97.29%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,556	503,800
Total NHS Trade Invoices Paid within target	2,405	503,800
Percentage of NHS Trade Invoices paid within target	94.09%	100.00%

The CCG supports the Better Payment Practice Code which requires the CCG to aim to pay 95% of all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

7.2 The Late Payment of Commercial Debts (Interest) Act 1998

The CCG did not make payments totalling more than £500 under this legislation in 2013/14

8. Income Generation Activites

The clinical commissioning group does not undertake any income generation activities.

9. Investment revenue

The CCG did not receive any investment revenue in 2013/14.

10. Other gains and losses

No other gains or losses have been recorded by the CCG during the financial year

11. Finance costs

The CCG did not incur any finance costs during 2013/14.

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

No gains or losses have been recognised by the CCG during the financial year resulting from transfers by absorption.

13. Operating Leases

13.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Ltd. For 2013/14, a transitional occupancy rent based on annual property cost allocations was agreed. This is reflected in Note 13.1.1.

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 a leased car.

Independent Sector Treatment Centres were opened in November 2009 at Emerson's Green, South Gloucestershire and at Cirencester Hospital, Gloucestershire. There is a service agreement between UKSH, the service provider, and the Department of Health to provide an agreed range of treatments for the term of the contract. This activity is 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 exists. The price within the service contract uses the NHS tariff for secondary care. The service payment to UKSH in 2013/14 was £6,650k.

13.1.1 Payments recognised as an Expense

	Land £000	Buildings £000	Other £000	2013-14 Total £000
Payments recognised as an expense				
Minimum lease payments	-	1,362	(0)	1,362
Contingent rents	-	-	-	-
Sub-lease payments	-	-	-	-
Total	-	1,362	(0)	1,362

13.1.2 Future minimum lease payments

	Land £000	Buildings £000	Other £000	2013-14 Total £000
Payable:				
No later than one year	-	-	-	-
Between one and five years	-	-	-	-
After five years	-	-	-	-
Total	-	-	-	-

13.2 As lessor

The CCG did not act as a lessor on any assets in the financial year.

14. Property, plant and equipment

The CCG did not own any land, buildings or dwellings throughout the year.

2013-14	Plant & machinery £000	Transport equipment £000	Information technology £000	Total £000
Cost or valuation at 1 April 2013	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	81	-	505	586
Adjusted Cost or valuation at 1 April 2013	81	-	505	586
Addition of assets under construction and payments on account	-	-	-	-
Additions purchased	-	-	-	-
Additions donated	-	-	-	-
Additions government granted	-	-	-	-
Additions leased	-	-	-	-
Reclassifications	(81)	81	-	-
Reclassified as held for sale and reversals	-	-	-	-
Disposals other than by sale	-	-	-	-
Upward revaluation gains	-	-	-	-
Impairments charged	-	-	-	-
Reversal of impairments	-	-	-	-
Transfer (to)/from other public sector body	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-
At 31 March 2014	-	81	505	586
Depreciation 1 April 2013	-	-	-	-
Adjusted depreciation 1 April 2013	-	-	-	-
Reclassifications	-	-	-	-
Reclassified as held for sale and reversals	-	-	-	-
Disposals other than by sale	-	-	-	-
Upward revaluation gains	-	-	-	-
Impairments charged	-	-	-	-
Reversal of impairments	-	-	-	-
Charged during the year	-	20	505	525
Transfer (to)/from other public sector body	-	-	-	-
Cumulative depreciation adjustment following revaluation	-	-	-	-
At 31 March 2014	-	20	505	525
Net Book Value at 31 March 2014	-	61	-	61
Purchased	-	61	-	61
Donated	-	-	-	-
Government Granted	-	-	-	-
Total at 31 March 2014	-	61	-	61
Asset financing:				
Owned	-	61	-	61
Held on finance lease	-	-	-	-
On-SOFP Lift contracts	-	-	-	-
PFI residual: interests	-	-	-	-
Total PFI & LIFT assets	-	-	-	-
Total at 31 March 2014	-	61	-	61

Revaluation Reserve Balance for Property, Plant & Equipment

	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Total £000's
Balance at 1 April 2013	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-
Revaluation gains	-	-	-	-
Impairments	-	-	-	-
Release to general fund	-	-	-	-
Other movements	-	-	-	-
At 31 March 2014	-	-	-	-

14. Property, plant and equipment cont'd

14.1 Additions to assets under construction
The CCG did not own any assets under construction at any point during the financial year.

14.2 Donated assets
The CCG does not own any donated assets.

14.3 Government granted assets
The CCG does not own any assets that have been funded through a Government grant.

14.5 Compensation from third parties
No compensation has been received or is due from third parties as a result of assets being either impaired, lost or given up.

14.6 Write downs to recoverable amount
The CCG inherited IM & T assets from Gloucestershire PCT and, following advice, they have been subjected to accelerated depreciation in order to write their net book value down to a recoverable value of zero.

14.7 Temporarily idle assets
There are no assets that are temporarily idle.

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

	2013-14 £000
Plant & machinery	Nil
Transport equipment	Nil
Information technology	505
Total	505

14.9 Economic lives

	Minimum Life (years)	Maximum Life (Years)
Transport equipment	3	3
Information technology	Nil	Nil

15. Intangible non-current assets
The CCG does not own any intangible assets.

16. Investment property

The clinical commissioning group had no investment property as at 31 March 2014

17. Inventories

The clinical commissioning group had no inventories as at 31 March 2014

18. Trade and other receivables

	Current 2013-14 £000	Non-current 2013-14 £000
NHS receivables: Revenue	1,827	-
NHS receivables: Capital	-	-
NHS prepayments and accrued income	-	-
Non-NHS receivables: Revenue	5,996	-
Non-NHS receivables: Capital	-	-
Non-NHS prepayments and accrued income	458	-
Provision for the impairment of receivables	(61)	-
VAT	26	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-
Interest receivables	-	-
Finance lease receivables	-	-
Operating lease receivables	-	-
Other receivables	104	-
Total	8,350	-
Total current and non current	8,350	
Included above:		
Prepaid pensions contributions	-	

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

18.1 Receivables past their due date but not impaired

	2013-14 £000
By up to three months	1,485
By three to six months	37
By more than six months	-
Total	1,522

£860k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

18.2 Provision for impairment of receivables

	2013-14 £000
Balance at 1 April 2013	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-
Adjusted balance at 1 April 2013	-
Amounts written off during the year	-
Amounts recovered during the year	-
(Increase) decrease in receivables impaired	(61)
Transfer (to) from other public sector body	-
Balance at 31 March 2014	(61)

The provision relates to a single supplier which had been overpaid by the CCG's financial services provider. Although a payment plan had been agreed, the first payment was defaulted upon and the case is now being pursued through a formal legal process.

19. Other financial assets

The CCG does not hold any financial assets.

20. Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

21. Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	-
Net change in year	30
Balance at 31 March 2014	30
Made up of:	
Cash with the Government Banking Service	29
Cash with Commercial banks	-
Cash in hand	1
Current investments	-
Cash and cash equivalents as in statement of financial position	30
Bank overdraft: Government Banking Service	-
Bank overdraft: Commercial banks	-
Total bank overdrafts	-
Balance at 31 March 2014	30
No Patients' money is held by the clinical commissioning group	-

22. Non-current assets held for sale

The CCG does not hold any non-current assets that are due for sale

23. Analysis of impairments and reversals

There were no impairments or reversals during the financial year

24. Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	14,511	-
NHS payables: capital	-	-
NHS accruals and deferred income	-	-
Non-NHS payables: revenue	2,771	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	25,181	-
Social security costs	80	-
VAT	-	-
Tax	85	-
Payments received on account	-	-
Other payables	322	-
Total	42,948	-
Total payables (current and non-current)	42,948	

Other payables include £111k of outstanding pension contributions at 31 March 2014

25. Other financial liabilities

The CCG does not have any other financial liabilities.

26. Other liabilities

The CCG does not have any other liabilities.

27. Borrowings

The CCG did not have any borrowings in the financial year.

28. Private finance initiative, LIFT and other service concession arrangements

The CCG had no PFI, LIFT or other service concession arrangements during the financial year.

29. Finance lease obligations

The CCG does not hold any finance leases.

30. Finance lease receivables

The CCG does not receive any funds from finance lease arrangements.

31. Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Legal claims	-	-
Continuing care	870	-
Other	-	-
Total	870	-

Total current and non-current

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-
Arising during the year	-	-	-	870	-	870
Utilised during the year	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	870	-	870
Expected timing of cash flows:						
Within one year	-	-	-	870	-	870
Between one and five years	-	-	-	-	-	-
After five years	-	-	-	-	-	-
Balance at 31 March 2014	-	-	-	870	-	870

The Continuing Care provision of £870k 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 2014 will be assessed and are expected to be paid within the 2014/15 financial year.

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2014 is £1,754k

32. Contingencies

The CCG has not recognised any contingent assets or liabilities.

33. Commitments

The CCG does not have any outstanding capital commitments and has not entered into non-cancellable contracts which are not leases, private finance initiative contracts or other service concession arrangements.

34. Financial instruments

34.1 Financial risk management

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

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group's Prime Financial Policies and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group's internal auditors.

34.1.1 Currency risk

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

34.1.2 Interest rate risk

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

34.1.3 Credit risk

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

34.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

34. Financial instruments cont'd

34.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	1,827	-	1,827
· Non-NHS	-	5,996	-	5,996
Cash at bank and in hand	-	30	-	30
Other financial assets	-	372	-	372
Total at 31 March 2014	-	8,225	-	8,225

34.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	14,511	14,511
· Non-NHS	-	27,951	27,951
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	327	327
Total at 31 March 2014	-	42,789	42,789

35. Operating segments

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

36. Pooled budgets

The pooled budget relates to Integrated Community Equipment Services with Gloucestershire Council. The clinical commissioning group's and consolidated group's shares of the income and expenditure handled by the pooled budget in the financial year were:

	2013-14 £000
Income	3,950
Expenditure	- 3,950

37. NHS Lift investments

The CCG has no investments in NHS LIFT schemes.

38. Intra-government and other balances

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	26	-	276	-
· Local Authorities	3,115	-	6,120	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	1,185	-	342	-
· NHS Trusts and Foundation Trusts	642	-	14,169	-
Total of balances with NHS bodies:	1,827	-	14,511	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	3,382	-	22,041	-
Total balances at 31 March 2014	8,350	-	42,948	-

39. 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.

	2013/14 Payments to Related Party £000
Dr Helen Miller (Clinical Chair of CCG)	282
Partner - The College Yard and Highnam Surgery	
Dr Caroline Bennett (CCG Member/GP Locality Lead)	559
Partner - Cotswold Medical Practice	
Dr Charles Buckley (CCG Member/GP Locality Lead)	311
Partner - Frampton Surgery	
Dr Malcolm Gerald (CCG Member/GP Locality Lead)	194
Partner - Romney House Surgery	
Dr Martin Gibbs (CCG Member/GP Locality Lead)	287
Partner - Blakeney Surgery	
Dr William Haynes (CCG Member/GP Locality Lead)	232
Partner - Hadwen Medical Practice	
Dr Hein Le Roux (CCG Member/GP Locality Lead)	102
Minchinhampton Surgery	
Dr Andy Seymour (CCG Deputy Clinical Chair)	108
Partner - Heathville Road Surgery	
Dr Jeremy Welch (CCG Member/GP Locality Lead)	47
Partner - Jesmond House Surgery	
Jonathan Jeanes (Interim Dir of Transformation/Service Redesign)	46
MD of Jeanes Consulting Ltd	
Dr Steven Allder (Secondary Care Doctor Advisor to CCG)	13
Consultant Neurologist (Plymouth Hospitals NHS FT)/Consultant for Kings Fund	

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

- 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 [e.g. 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.

40. Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group or consolidated group.

41. Losses and special payments

41.1 Losses

There have been no losses reported during the year.

41.2 Special payments

	Total Number of Cases 2013-14 Number	Total Value of Cases 2013-14 £'000
Compensation payments	-	-
Extra contractual Payments	-	-
Ex gratia payments	1	2
Extra statutory extra regulatory payments	-	-
Special severance payments	-	-
Total	1	2

42. Third party assets

The CCG held no third party assets.

43. Impact of IFRS

There has been no in-year financial impacts regarding the introduction of IFRS.

44. Analysis of charitable reserves

The CCG does not hold any charitable reserves.