NHS
Gloucestershire
Clinical Commissioning Group

Annual **Report**

Highlights of **2018/19**

1 A MESSAGE FROM

It's great to highlight the continuing progress being made by the CCG and our care partners as we develop support and services in Gloucestershire and put the building blocks in place for an NHS that can meet the needs of future generations.

In May, Gloucestershire was named as one of only 14 Integrated Care Systems (ICS) in the country which is testament to that progress and our commitment to work ever closer together to meet the needs of local people.

We know that we face significant challenges such as a growing population with more complex needs, increasing demand for services, recruiting and keeping enough staff with the right skills and pressure on money.

Looking forward, as part of the 'One Gloucestershire Way' we will be placing even greater emphasis on preventing ill health, helping people to live in more active communities with strong networks of support.

We will be supporting people to look after themselves when they can, but when they do need the help of the NHS, we will ensure people are able to access consistently high quality, safe, physical and mental health care.

A significant feature of this year has been development of Primary Care Networks and Integrated Locality Partnerships, supporting our shared goal of providing as much support and care in, or near, home, using local knowledge, networks and skills.

GP practices are working together to provide more appointments and teams of health and care professionals are working together in surgeries, neighbourhoods and homes to support people to recover from illness and stay independent for longer.

Gloucestershire is also striving to make sure that when people are really unwell, specialist hospital and mental health services are truly outstanding and comparable to the best in England.

Alongside conversations with local people and partners, we will be taking a logical approach to developing priorities and proposals for how we organise services and support across the county to meet the challenges of the future and make best use of the Gloucestershire pound.

Thank you for your support as we work to improve the health and wellbeing of the population.

Mary Hutton

Dr Andy Seymour

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3 HIGHLIGHTS OF THE YEAR

This summary provides an overview of highlights of the year

Keeping healthy and supporting active communities

22,500
pupils from 127 schools – Daily Mile

- More than 160 county schools learn about keeping healthy through Facts4Life
- 34 businesses receive Workplace Wellbeing Charter Awards as they create healthier and happier places to work for staff
- £1.2m pledged by CCG and partners to help get 30,000 inactive people doing daily exercise through Gloucestershire Moves
- More than 22,500 pupils from 127 schools walk, jog and run their way to better health thanks to the Daily Mile
- Young people walk and cycle over 74,487 miles as part of the 'Beat the Street' initiative

- More than 3,000 people with, or at risk of, diabetes taking positive steps to improve their health through the diabetes prevention programme and KiActiv health coaching
- 3,500 local people referred by GPs and others to community activities or support through 'Social Prescribing'
- Over 150 people with long term conditions improve their quality of life and build confidence through the Live Better to Feel Better programme

100,000
additional GP surgery appointments available

Developing community support and services

- Over 100,000 additional GP surgery appointments made available this year in the daytime, evening and weekends
- More health experts work in, and with, local GP surgeries to provide care and free up GP time e.g. 40 clinical pharmacists and physiotherapists, paramedics and mental health workers
- Inspiring and motivating 30 early career GPs to connect with Gloucestershire, as part of the Next Generation GP scheme in partnership with the Primary Care Training Hub
- 46,000 referrals to integrated health and social care community teams, 7 days a week. 1,300 patient contacts a month with the rapid response service
- Community teams provide care advice and support to thousands of people living with frailty and dementia to help them remain independent at home. A new complex care at home service is supporting Gloucester, Cheltenham and the Forest of Dean
- Over 80 people supported through the 365 day a year Learning Disability Intensive Support Service – preventing the need for stays in hospitals and facilities outside the county.

“

We want every person in every community to receive really good support and services

3 HIGHLIGHTS OF THE YEAR

Improving mental health

- 900 children and young people receive on-line and face to face counselling through Teens in Crisis
- 19 schools accredited as part of the Mental Health Champions Award
- £300,000 spent to employ mental health workers in schools and;
- £5 million for Gloucestershire to become a 'trailblazer' for mental health in schools. 4 teams will support primary, secondary and special schools
- The Perinatal Mental Health service for expectant and new mums is further developed.

900
Young people receive counselling support

Early support and improving the way services work

- 30% reduction in MSK hospital outpatient appointments with specialist therapists reviewing patients with musculoskeletal conditions
- 500 people a month helped by community eye care services at local high street opticians, reducing the need for hospital appointments
- £750,000 less spent on opioids (drugs) by supporting people to manage their pain and live well
- Continuing the successful Macmillan GP masterclasses to support early cancer diagnosis – 1,200 GP attendances over the last 4 years
- 1,100 people with cancer supported by the Macmillan rehabilitation programme after diagnosis and treatment.

500

people a month helped by community eye care services

High quality, timely specialist hospital services

- 89.6% of patients seen within 4 hours at the A&E Departments compared to 86.7% in 2017/18
- 12% increase in the number of hip and knee replacements and fewer cancelled operations
- Quicker access to early cancer care – hundreds more patients see a specialist, have tests and start treatment with a single hospital visit
- Over 3,500 older people with signs of frailty receive specialist assessment on arrival at the Emergency Department 'front door' with support to return home more quickly

4 PERFORMANCE REPORT – AN OVERVIEW

Performance Report – an overview

Over the last twelve months we have seen many achievements, but also faced some challenges. This section of the report provides you with an overview of our Clinical Commissioning Group (CCG), its main objectives, strategy, performance and principal risks in-year.

About NHS Gloucestershire Clinical Commissioning Group

NHS Gloucestershire Clinical Commissioning Group (CCG) was established on the 1 April 2013 and buys (commissions) services on behalf of patients registered with Gloucestershire GPs to meet the health needs of the county's population.

The CCG is a clinically led organisation with 74 GP member practices working across 14 Primary Care Networks (PCNs). Alongside health and care partners they help to shape local support and services.

The CCG Governing Body and its member practices have an important responsibility to make best use of available resources, based on clinical evidence of what works well and ensure that patient safety and quality of services is paramount.

The CCG commissions (buys) a wide range of hospital, community, mental health, learning disability and primary care (GP) services. From 1 April 2015, the CCG was approved to take on the delegated commissioning of primary medical care services. This means the CCG took on responsibility from NHS England for buying of primary care (GP) medical services.

A key role of the CCG is to work with all health providers and other organisations on the delivery and planning of health and social care services to ensure that we work together to ensure high quality services and support to Gloucestershire residents. This includes areas such as:

- meeting national and local service standards such as waiting times
- prevention, empowering people to self-manage their health conditions where appropriate and working with partners to develop active communities
- developing community services and support, with the aim of reducing the need for hospital stays, but work to ensure that safe, timely and effective hospital care is there when needed
- ensuring that the patient experience of services and the effectiveness of services is a good as it can be
- housing, the voluntary and community services.

Constitution

The CCG appointed a governing body to discharge the CCG responsibilities on their behalf. It includes four independent lay members as well as GPs, a secondary care doctor, an independent nurse member and executive members.

Lay members have been appointed to bring specific expertise and experience to the work of the governing body. Their focus is strategic and impartial, providing an external view of the work of the CCG that is removed from the day-to-day running of the organisation. Each lay member for Gloucestershire has specific skills which enable them to carry out this role.

Sub committees of the governing body monitor the controls in place to ensure the CCG is carrying out its functions in an effective manner.

The CCG employs 364 (297 FTE) members of staff who work alongside the GP members to carry out the work of the CCG as set out in its plans and priorities.

The Gloucestershire Population

The CCG covers a population of 650,000 registered with a Gloucestershire GP; with 71% living in an urban area and 29% in a rural area.

There are pockets of deprivation in the county although it is lower than average. Life expectancy is also better than the average; however, this masks significant differences between parts of the population.

Life expectancy at birth			
	Least deprived area	Most deprived area	Average Gloucestershire
Male	83 years	73.6 years	80 years
Female	85.4 years	79.4 years	83.6 years

The major causes of death are cancer, cardiovascular and respiratory problems.

Our Providers

We commission (buy) services from a range of providers including:

- Gloucestershire Hospitals NHS Foundation Trust
- Gloucestershire Care Services NHS Trust
- [2]gether NHS Foundation Trust
- South Western Ambulance Service NHS Foundation Trust
- General Practices
- Third sector organisations
- Independent Care Homes & Hospitals.

2018/19

2018/19 was the second year of implementation for the Gloucestershire Sustainability and Transformation Plan (now the Integrated Care System); a plan for the health and care system which built on work already underway within Gloucestershire.

Core members of the STP/ICS were the CCG, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Care Services NHS Trust, [2]gether NHS Foundation Trust, South Western Ambulance Service NHS Foundation Trust and Gloucestershire County Council.

The key themes within the work programme were:

- Enabling Active Communities: Focus on helping people to stay healthy and avoiding being unwell and the development of strong networks within communities, including social prescribing
- One Place: Development of 16 health and social care communities based around clusters (now 14 Primary Care Networks) of existing GP practices to better manage the care for people with long term conditions and prevent unnecessary hospital attendances, using the resources of the area in a more integrated manner
- Develop further the urgent care model and 7 day services further shifting the provision of care from an acute setting to community and primary care
- Clinical Programme approach: Each clinical programme group (CPG) covers a condition or group of conditions and involves medical and other professionals, VCS and patient representatives working together to improve the patient's journey through care. The approach ensures care is safe, joined up and provides value for money. It places an emphasis on prevention and self-management advice at an early stage
- Reviewing evidence of clinical effectiveness to ensure that services commissioned have an evidence base.

To help deliver these, there were a number of supporting 'enabling' cross-cutting programmes:

- One Gloucestershire Improvement Community – this is focussed on the implementation of a quality improvement methodology across Gloucestershire when services are changed
- Estates – this is reviewing the estate across Gloucestershire to look at how this can be improved
- Workforce – this is focussed on planning the workforce requirement for the future and considering the skills and expertise that will be required

- IM&T – this is focussed on ensuring that we have a robust IT infrastructure within Gloucestershire and developing the digital agenda to support care professionals delivering care in an integrated health and care system
- Primary care – this focussed on the development of primary care in a sustainable way to deliver care using new service models.

In recognition of the progress being made towards more integrated working, Gloucestershire was confirmed as an Integrated Care System (ICS) in 2018/19.

ICSs are systems in which NHS commissioners and providers, working closely with GP networks, local authorities and other partners, agree to take shared responsibility (in ways that are consistent with their individual legal obligations) for how they use their collective resources to improve quality of care and health outcomes.

They are expected to make faster progress than other health systems in transforming the way care is delivered, to the benefit of the populations they serve.

This brings a new collective responsibility to go beyond a shared desire to deliver the strategic plan as embodied by the STP.

ICS local priorities and deliverables

In becoming an ICS, Gloucestershire committed to making rapid progress in the following areas:

- Ensuring that 100% of its population are covered by Primary Care Networks (PCNs) in 2018/19, delivering the vision set out in the GP Five Year Forward View strategy and ensuring the benefits of integration are achieved through the establishment of the Integrated Locality Boards (ILPs)
- To enhance collaboration across its system to ensure pathways are delivered seamlessly across primary, community and acute care
- To build on its governance arrangements initiated through the STP, to ensure shared accountability for delivery of outcomes
- To have a specific focus in 2018/19 on recovery of the following key areas:
  - Delivery of the patient administration system implementation recovery plan in line with the plans agreed with NHS Digital and NHS Improvement
  - Delivery on A&E waiting times and streamlining assessment with more senior clinical review
  - IAPT Service Development Improvement Plan (SDIP) including delivery of IAPT for those with long term conditions
  - Reducing delays when patients are ready to leave acute and community hospital beds
  - Improvement priorities for children's and young people's mental health access standards including services for those with eating disorders and;
  - Cancer waiting times, in particular the 62 day standard
- to develop a shared system financial control total (aiming for delivery of this in 2019/20 financial year) and the development of the associated financial governance and risk sharing arrangements to support this
- to support clinical leadership across its programme
- to deliver system level workforce planning.

The wider partnership in the ICS work programme includes the District Councils, Gloucestershire Police, the Police and Crime Commissioner, the Voluntary Community and Social Enterprise (VCSE) sector, the public, Healthwatch and partner agencies including Health Education England and the Academic Health Science Network and specialist commissioning.

Key risks identified within the ICS are:

- Delivery of Constitution targets remains a challenge
- Transformation changes: slippage in programmes to deliver the changes as a result of capacity, cultural or other constraints
- Slippage in delivery of financial savings due to delays in planned programmes, unexpected cost pressures
- Recruitment and retention of key staff within the health and social care system

The performance of the organisation 2018/19

The CCG in 2018/19 worked with system partners and has a strong commitment to collaborative working. 2018/19 has been a challenging year financially.

We have made significant progress this year in delivering on our strategic objectives working closely with local partners and also in developing the Gloucestershire ICS Plan. This plan covers the period to 2020/21 and builds on the previous five year plan for Gloucestershire.

This includes:

- Building a sustainable and effective organisation with robust governance arrangements
- Developing strong leadership as commissioners
- Working with our partners and patients to develop and deliver ill health prevention, supporting people to take more control over their health and well-being and enabling active communities and building strong networks of support
- Transforming services with partners to meet the future needs of the population using the Clinical Programme Approach
- Working with patients, carers and the public to inform decision making and develop services.

Principal risks and uncertainties

There were a number of key risks identified by the CCG during 2018/19. These are summarised below and further details can be found in the Governance Statement.

- Implementation of an electronic patient administration system within our main acute provider has led to reporting issues for clinical correspondence, national performance reporting and contractual management
- Risk around the current lack of knowledge of NHSE strategy for specialised services and engagement with NHSE in relation to specialised services
- Risk that system partners will be unable to effectively deliver a timely and coordinated approach to patient flow and discharge ensuring a reduction of patients who remain in the acute trust when medically stable and with a length of stay greater than 14 days
- Risk to Non-Emergency Patient Transport delivery, including patient experience due to operational issues, financial sustainability of the Non-emergency patient transport contract and procurement risks for the new contract
- South West Ambulance NHSFT has identified a risk in the South West to patients due to call stacking. In Gloucestershire the risk is in category 2 patients where waits are longer than target times; category 1 patients are responded to within the required times
- Risk that the transfer in providers of the OOH service from SWAST to CareUK leads to an inability to deliver an effective service during transition due to workforce issues (filling shifts/rostering of staff)
- Continued financial challenge and the need to accelerate pace of change on transformation to maximise the use of the Gloucestershire pound.

No significant risks have been identified that specifically relate to:

- The effectiveness of governance structures
- Responsibilities of directors and committees
- Reporting lines and accountabilities between the governing body, its committees and sub-committees and the executive team; or
- The submission of timely and accurate information to assess risks to compliance with the Clinical Commissioning Group's licence.

An explanation of the going concern

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

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

The CCG has prepared a five year financial plan which shows the organisation achieving its financial duties in each of the respective years and has considered through its Audit Committee, the appropriateness of this approach. No issues were noted which would affect this, although the level of financial challenge has significantly increased. The plan has been developed as a part of the ICS process and brings in risks identified within Gloucestershire as a whole in addition to those specific to the CCG.

This is in addition to the Secretary of State direction that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern. As a result, the governing body of the CCG has prepared these financial statements on a going concern basis.

Building a sustainable and effective organisation with robust governance arrangements

The CCG undertook a comprehensive review of its governance structures in 2015/16 when it took on delegated commissioning for primary care. Since then, systems and processes have been reviewed in practice and changed where necessary; this includes the Conflicts of Interest Policy.

Details of our Governance arrangements are set out in the Governance Statement in this Report. Each Committee within the organisation has reviewed their effectiveness and produced an annual report.

The CCG has also discharged its duties under section 14R of the Health and Social Care Act 2012. The CCG has developed a quality strategy 'Our Journey for Quality' (see Quality Improvement section).

Developing strong leadership as commissioners

We have further developed our leadership role in 2018/19.

The CCG Accountable Officer is the lead for the Gloucestershire Integrated Care System (ICS) and, with the other Chief Executives, is now driving forward the development of the Gloucestershire ICS in line with the agreed plan.

The STP plan has four key programme areas, each one led by a Chief Executive.

The governance structure also includes four enabling work streams and an ICS Strategic Stakeholder Group which includes a range of stakeholders, including District Councils and third sector organisations.

As part of the above, the CCG has also:

- Supported the development of sustainable primary care
- Been an active partner on the Gloucestershire Health and Wellbeing Board; supporting the delivery plans on tackling health inequalities, improving mental health, reducing obesity, improving health and wellbeing into older age and reducing the harm caused by alcohol
- Played a role on the Leadership Gloucestershire Board.

We are assessed on a quarterly basis by NHS England (CCG Assurance Framework) and have been assured as good for leadership.

Our Financial Performance

The CCG achieved its financial duties for 2018/19 with a surplus of £0.005 million. The details of the financial position are given below:

Financial Summary	Programme Costs including primary care £m	Running Costs £m	Total £m
Revenue resource limit	856.540	13.71	870.253
Total net operating cost for the financial year	856.536	13.712	870.248
Surplus in year	0.004	0.001	0.005
Brought forward surplus			21.465
Cumulative surplus			21.470

There have been a number of financial pressures in year including:

- Additional costs due to significantly increased costs of drugs primarily due to high prices leading from central classification of specific drugs as 'no cheaper stock obtainable'. The CCG has no option other than to pay the prices set
- Additional costs resulting from continuing health care, funded nursing care and individual placements
- Increased costs from elective (planned) care, particularly within the independent sector.

However, within the year the CCG implemented a number of savings schemes which have delivered results, a number of schemes started in year will deliver savings in 2019/20.

Examples include:

- Medicines management optimisation – focus on improving the management of prescribing where clinical effectiveness evidence is low, reducing waste
- Pathway redesign, further implementation of ophthalmology changes, implementation of changes to musculoskeletal pathways for patients which should mean that patients are seen by the right professional first time.

At the end of the financial year, the CCG delivered a surplus of £0.005m; this is an achievement given the significant financial pressures faced by the CCG in 2018/19. The CCG's cumulative surplus at the end of 2018/19 is £21.470m.

The cumulative surplus above 1% of the CCG's allocation is available to the CCG in future years to use non-recurrently, this is subject to NHS England agreement of the CCG's plans.

In addition, the CCG:

- Remained within its maximum cash drawdown as agreed with NHS England
- Complied with the Better Payments Practice Code (details provided within note 6 of the annual accounts).

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

For the financial year 2019/20, the CCG will receive an additional allocation of £2.65m for delegated primary care and £43.5m for all other areas of expenditure excluding running or administration costs. This includes Gloucestershire's share of the additional funding announced in the autumn for the NHS.

The level of allocation increase is higher than the previous years because of the additional autumn funding, but includes funding for two years of the new pay deal, transfers from the provider sustainability funding and also some allocations previously funded separately.

However, the financial situation remains very constrained for Gloucestershire as a whole and the focus on initiatives that improve efficiency and value for money needs to remain intensive. The CCG's plans for 2019/20 show an in-year position of breakeven and complies with the NHS England business rules including investments in primary care and mental health.

There is a challenging programme of savings and opportunities over the period 2020/21 based on the Right Care Programme and other benchmarking information. These are informing the work streams within the Gloucestershire ICS. Savings for the CCG will fall into two main areas:

Transactional Savings:

- The agreement of evidence based activity planning and activity management actions with providers including appropriate clinical controls on the access to and type of treatment
- Engagement and influence on primary care prescribing behaviour and costs
- Procurement savings on contracts.

Service Design/Redesign:

- For example the new pathways and services for Musculoskeletal and Ophthalmology services
- Informed by the CCG's participation in the Right Care Programme we are using benchmarked intelligence on spend and outcomes to focus our improvement activities.

Gloucestershire providers, in order to meet their financial control totals for 2019/20 will need to make significant savings.

5 PERFORMANCE REPORT – ANALYSIS

Performance Report – Performance analysis

How do we monitor performance?

The CCG's Governing Body is responsible for discharging the duties of its constitution, which includes monitoring and scrutinising performance. The Governing Body receives an integrated performance report at their bi-monthly meetings in public.

The CCG has formal committees of the Board which scrutinise how the CCG and our health providers are performing, these are the Audit Committee and the Integrated Governance and Quality Committee (for more information about the committees and their purpose please see page 46; the Governing Body receives more in depth Finance and Performance updates on a monthly basis at Development sessions.

The A&E Delivery Board also has a role to play in monitoring performance. Its members include the chief operating officers from NHS organisations in the county.

The group aims to develop and maintain resilience across the system and support effective leadership and operational management of high quality care delivery.

The CCG is also assessed by NHS England on a quarterly basis under the Improvement and Assessment Framework.

Sustainable Development

Climate mitigation has reached a new urgency and NHS Gloucestershire Clinical Commissioning Group (the CCG) is committed to play its part.

The CCG continues to use a sustainable approach when commissioning healthcare services, taking into consideration the use of its financial, environmental and social resources while maximising health and health outcomes for its current and future population.

The CCG's Executive Nurse takes responsibility for Sustainability at Board level.

Action on sustainability continues to be initiated through the CCG's Joint Staff Consultative Forum, which regularly includes sustainability as an agenda item and promotes sustainability through staff briefings.

Honouring the Public Service Value Act (2012), the CCG considers the social and environmental impact of all its procurement and commissioning activities.

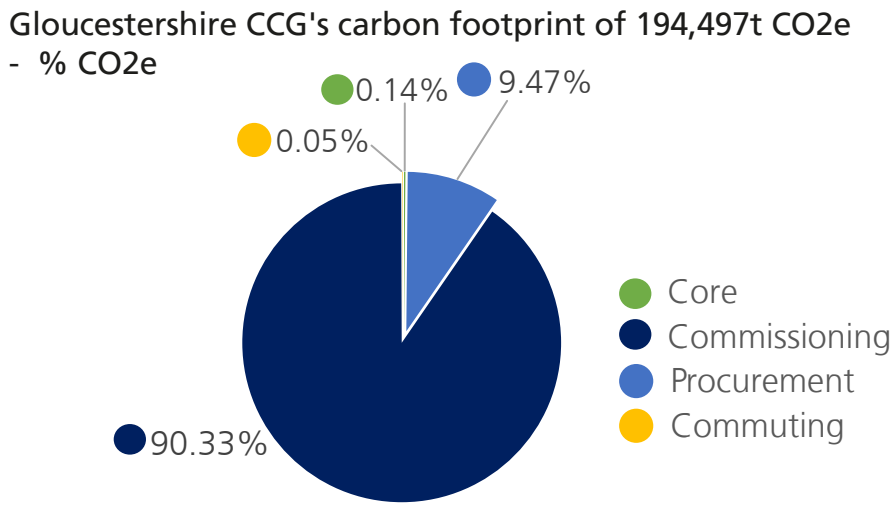
The CCG carries out a Quality and Sustainability Impact Assessment for all proposals and contracts which would lead to changes in the way services are commissioned and delivered. Where sustainability is considered during competitive tendering, it is incorporated in the service quality weighting using a standard scoring matrix or methodology.

The CCG has acknowledged the NHS's ambitious target to reduce its carbon emissions[1] by 80% by 2050 in line with the Climate Change Act (2008). Since 2014-15, the CCG has completed the SDU's sustainability reporting template annually to monitor its own progress in emissions reduction.

In 2018/19, the total carbon footprint[2] of the CCG was 188,942 tonnes of carbon dioxide equivalents (tCO2e). In common with all previous years the commissioning of services was the highest contributor to the CCG's greenhouse gas emissions, being responsible for 90.0% (170,143 tCO2e) of the CCG's total carbon footprint. Internal procurement (CCG office procurement plus pharmaceuticals) is the second highest contributor, responsible for 9.8% (18,419 tCO2e) of the CCG's emissions.

Core emissions, which cover those released during energy and water use, waste disposal and business travel, make up only a very small proportion of the CCG's carbon footprint – 0.2% (275.54 tCO2e). Staff commuting adds another 0.06% (105 tCO2e).

1. In this report the terms carbon emissions, greenhouse gas emissions and carbon footprint are used interchangeably.
2. The term carbon footprint is used to describe the sum of all greenhouse gas emissions released in relation to an organisation, product or service expressed in carbon dioxide equivalents.



Graph 1: ***Proportions of 2018-19 NHS Gloucestershire CCG's carbon footprint***

Compared to last year, the CCG's 2018-19 carbon footprint has increased by 5% – see Table 1. This increase is mainly due to a rise in the greenhouse gas emissions embedded in commissioning and in staff commuting.

Table 1: ***Comparison of NHS Gloucestershire CCG's carbon footprint 2016/17 and 2017/18***

	Carbon Footprint (tCO2e)		
Category	**2017-18**	**2018-19**	**Increase/ decrease**
Core energy use	290.56	275.54	-5.17%
Procurement	18,148	18,419	1.49%
Commissioning	162,222	170,143	4.88%
Commuting	97	105	8.25%
Total	**180,758**	**188,942**	**4.53%**

Staff commuting

The CCG's carbon footprint due to staff commuting has increased by 8%. This is due to an increase in staff whole-time equivalent (a number of ICS staff are hosted by the CCG) and based on the assumption that every member of staff goes to work by car. An annual staff travel survey will be conducted during 2019/20 to ensure a more accurate analysis of the commuting behaviour of staff and the carbon emissions embedded in commuting.

The CCG has put incentives in place to reduce commuting emissions. It is offering a car share and a bike to work scheme. In 2018/19 the CCG organised a roadshow for the Bike to Work scheme to encourage more employees to sign up. As a result, five staff members have joined the scheme last year.

Procurement

There has been a small rise of 1.49% in greenhouse gas emissions associated with the CCG's overall procurement – from 18,148 tCO2e in 2017-18 to 18,419 tCO2e in 2018-19.

Within procurement, pharmaceuticals are the highest contributor of greenhouse gas emissions (97%). Compared to last year, the carbon footprint of the CCG's pharmaceuticals increased by only 1%.

The CCG has carried on working actively to reduce the carbon emissions associated with prescribing by continuing to expand two programmes:

- The number of general practices who have clinical pharmacists has gone up from 33 last year to 40 in 2018/19. The clinical pharmacists help with prescribing and medication-related issue. This helps to alleviate the pressure on GP workloads whilst ensuring that patients receive expert advice. Moreover, it reduces medicine waste and therefore the greenhouse gas emissions embedded in the production and disposal of medicine

- There are now 23 general practices which have signed up to the Prescription Ordering Line 'POL' service. An increase of 64%. The service was introduced by the CCG in July 2017, giving patients a dedicated phone line to request repeat prescriptions. It saves administration time at both the surgery and pharmacy plus patients' time as they do not have to drop off their prescription requests at the surgery. It also ensures that medications patients do not need, are not re-ordered. The resulting reduction in patient travel and medicine waste will have a positive impact on the environment.

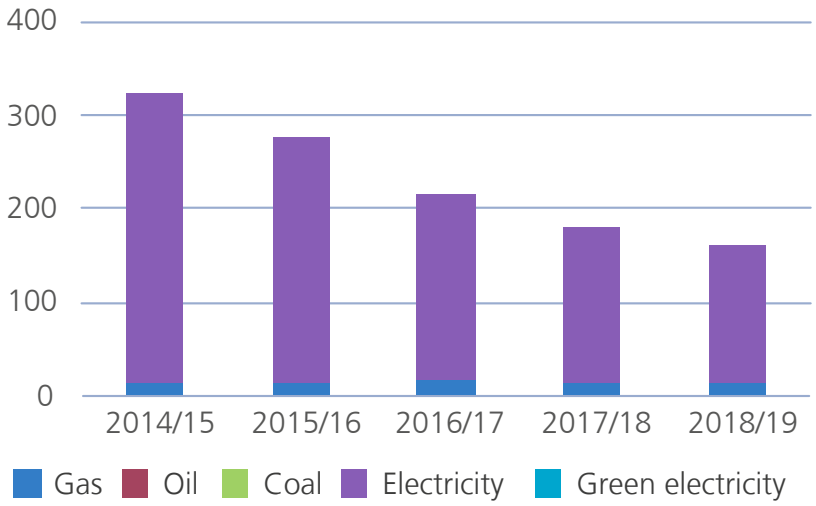
2018/19 has seen a 15% rise in greenhouse gas emissions associated with information and technology as the CCG received extra funding to improve Wi-Fi services for GPs. The carbon footprint due to food and catering for the CCG is very small; this has increased in year and relates to additional training and other events for clinicians, staff and cross-organisational events.

However, the carbon emissions associated with paper products has been reduced by 22% to 9.1 tCO2e. The CCG has encouraged its staff 'to think before we print'. Moreover, photocopiers now indicate the cost of printing urging staff to think if photocopying is really needed.

Core emissions

The 5% cut in the CCG's core emissions is due to a reduction in carbon emissions related to electricity, water use and waste disposal – see graph 2 and table 2.

Graph 2: ***Carbon emissions due to energy use (tCO2e)***



Electricity and business travel are the biggest contributor to the core emissions. While emissions from electricity use have gone down by 13% due to increasing decarbonisation of the grid, carbon emissions associated with business travel have gone up by 8% due to an increase in business travel by car and rail.

The carbon emissions embedded in water use and waste disposal have decreased by 14% and 91% respectively. The major reduction in waste disposal emissions is due to the fact, that domestic waste gets segregated at the waste plant. Another 22% went into recycling and 73% went to heat recovery. Only 5% ended up in landfill.

Table 2. ***Comparison of NHS Gloucestershire CCG's core greenhouse gas emission 2017-18 and 2018-19***

	Carbon footprint (tCO2e)		
Core category	2017-18	2018-19	Increase/ decrease
Electricity	166	144	-13.25%
Gas	15.4	16.9	9.74%
Business travel	105	113	7.62%
Water	1.62	1.4	-13.58%
Waste	2.54	0.24	-90.55%
Total	290.56	275.54	-5.17%

Benchmarking the CCG's greenhouse gas emissions per full-time equivalent, population served and operational expenditure has seen an increase compared to last year – 2%, 9% and 4% respectively. This is due to a rise of the CCG's total greenhouse gas emissions of 8%.

Commissioning

The national NHS Long Term Plan (LTP) was published in January 2019. In response the CCG has been engaging on the development of a local NHS Long Term Plan this spring. With the Long Term Plan's emphasis on prevention, support for self-care and nurturing of community strength and assets the CCG is taking a big step towards a more sustainable health system.

Though there has been a 5% increase in carbon emissions associated with commissioning, the Long Term Plans' initiatives are predicted to alleviate the pressure on environmental and social resources whilst improving patient care. Below are a number of examples.

Social prescribing

In 2018/19, GPs and others in Gloucestershire have referred over 3,500 people to social prescribing through the community and wellbeing service.

The 2016 evaluation[3] of social prescribing in Gloucestershire showed that social prescribing improved patients' wellbeing, reduced hospital emergency admissions and the number of GP appointments, including GP home visits and calls to the GP.

With a visit to the A&E department and a GP consultation being responsible for 13.8 kgCO2e/visit and 1.14 kgCO2/visit respectively, social prescribing has the potential to reduce the impact of healthcare on the environment.

#NoShow Campaign

Recently, the CCG ran a '#NoShow' campaign to reduce the number of missed GP and hospital appointments, as last year there were 125,000 missed GP and 60,000 missed hospitals appointments which equals 30,000 hours of NHS time.

The campaign encourages people to call the GP surgery or hospital outpatient department to cancel in advance when they can't make it. The CCG will evaluate the impact of the campaign next year.

Beat the Street

Obesity and a lack of exercise can lead to an increase in non-communicable diseases resulting in a rising demand for healthcare. Gloucestershire CCG worked in partnership with Gloucestershire Moves and Gloucester Intelligent Health to organise the 'Beat the Street' challenge which ran from 7 June to 19 July 2018. Beat the Street is a free fun walking, cycling and running game, to get the whole community moving. During the challenge 10,400 people participated and 74,487 miles were travelled.

Living well with disability

The CCGs 'living well with disability' programme is working towards ensuring that the majority of people with learning disabilities have an annual health check. It is also providing 365 day a year support through the Learning Disability Support Service (LDISS) which will help to avoid stays in hospital and facilities outside the county. This will have a positive impact on their lives.

Moreover, every low intensity inpatient bed day causes around 37.9 kgCO2e which the programme aims to avoid.

Provider performance

The CCG understands that most of its carbon emissions derive from its commissioning activity. To alleviate its environmental impact, the CCG supports sustainability improvements across provider trusts.

All providers are asked to demonstrate their plans and policies on sustainability as part of the CCG's contracting processes. Below is a summary of the providers' highlights in sustainability in 2018/19.

3. http://www.glosvcsalliance.org.uk/wp-content/uploads/2017/02/Social-prescribing-Evaluation-report-FINAL-201216.pdf

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Hospitals NHS Foundation Trust received a certificate in recognition of 'Excellence in Sustainability Reporting' for the 2017/18 annual sustainability report from the Sustainable Development Unit for NHS England and Public Health England – with the Healthcare Financial Management Association and NHS Improvement.

The Trust continues to embed sustainability within its day to day business and has a Sustainable Development Plan for 2015/2020. Their carbon emissions data for 2018/19 is not yet available to include in the CCG's sustainability report, but will be ready for review in their own annual report for 2018/19.

Over the last year the Trust has worked on sustainable energy, travel and catering initiatives.

Energy

Vital Energi has installed a 2.5MW CHP at Gloucestershire Royal Hospital and the installation of LED lighting is continuing.

Travel

- In September 2018, two more stops have been added to the shuttle bus' route between the Arle Court Park and Ride in Cheltenham and Cheltenham General and Gloucestershire Royal. The new stops give two residential areas and Cheltenham railway station users easy access to the hospital sites. Over 17,200 journeys are now made each month with about 75% of those made by staff. From April 2018 to March 2019, the shuttle bus covered 178,816 miles, carried 212,224 passengers and produced 188 tCO2
- A reduced fare is available to Trust staff with two local bus companies, one of which also offers a monthly travel pass paid through a salary sacrifice arrangement proving further savings to the staff member
- New parking permit arrangements: Staff who work standard office hours and who live within 40 minutes travel by public transport will no longer be eligible for a car parking permit. The changes will ensure that staff who use their own vehicle on Trust business and those who work shifts are able to park on site, will support staff health and wellbeing and reduce the congestion on the hospital sites
- The Trust continues to offer a salary sacrifice scheme for the purchase of bicycles
- The Trust offers staff the ability to lease a new car through a salary sacrifice scheme with the car being restricted to produce up to 110g/km of carbon emissions. Moreover, the lease scheme includes a carbon offsetting initiative.

Catering

- The in-house Catering team is compliant in the CQUIN improvement programme (2017/18-2018/19) to reduce sugar levels and make healthier food and drink more widely available on NHS premises. The Catering department follows the Government Buying Standards, fresh meat is from the Red Tractor assurance scheme and all fish and palm oil products are from sustainable sources. Dairy and bakery products, fruit and vegetables and fresh meat are all from suppliers within the county or the South West
- The in-house production of cakes, sandwiches and salads has enabled a move to paper and cardboard packaging for these items and hot food take-out containers are now bio-degradable. Plastic disposable cutlery is now only available to customers who purchase takeaway food, helping to reduce its usage. Cardboard and cans are recycled and provide a small income for the Trust. All plastic products are recycled and the department continues to reduce disposables. Catering no longer uses black plastic for ready meals containers or disposable coffee lids as they were not recyclable and have moved to a white plastic instead
- Retail outlets are encouraging the use of re-usable cups by offering a bamboo travel mug at a promotional price. They also offer a discount to customers who bring their own mugs for hot beverages and have signage by their hot drinks machines encouraging customers to use the china mugs rather than disposables.

Trust merger

[2]gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust are merging later in 2019. Sustainability updates from each Trust from 2018/19 are included separately below.

[2]gether NHS Foundation Trust

In its annual report for 2017/18, the Foundation Trust has set out is ambitious carbon reduction targets.

The Trust aims to reduce its carbon footprint by 34% by 2020 based on their 2008 baseline. For its Hereford sites, where there is no 2008 baseline data available, 2gether aims to reduce its carbon emissions by 2% year on year.

In last year's report, the CCG described the Trust's initiatives in waste reduction through the platforms 'warpit' and 'gumtree' and their efforts in improving their energy efficiency.

We are looking forward to hearing about the Trust's most recent activities in improving their sustainability.

Gloucestershire Care Services NHS Trust

Building on 2017/18 when Gloucestershire Care Services NHS Trust completed the installation of photovoltaic panels at six out of seven of its community hospitals, the Trust is continuing to work towards greater energy efficiency.

In each of the Trust's large capital refurbishment schemes undertaken in 2018/19 – Southgate Moorings in Gloucester, Cashes Green Ward in Stroud, the Complex Leg clinic in Cirencester, as well as the scheme currently in progress at the Independent Living Centre in Cheltenham – modern LED lighting was/is being installed as part of the works.

That apart, the focus has been on replacing old inefficient kit with more modern, efficient systems - the most significant example being new boilers installed at Stroud Maternity Hospital.

South Western Ambulance Service NHS Foundation Trust

The Ambulance Trust planned several sustainability initiatives for 2018/19.

The Trust intended to review the water market and consider options for frameworks.

They also proposed to carry out a travel survey and develop travel plans for all major sites.

Risk assessments concerning pollution due to fuel storage and vehicle cleaning and remedial works were scheduled for all priority sites.

Moreover, the Trust intended to introduce Hybrid cars where viable. We are looking forward to hearing about their initiatives.

Quality Improvement

The Health and Social Care Act 2012 S26 (14R) sets out that Clinical Commissioning Groups have a duty to continually improve the quality of service. Our governance structure (see Quality & Governance Committee – page 47) ensures that Quality is embedded across the local health care system, supported by the development of our Quality Assurance Framework, which monitors and challenges quality in the organisations we commission services from.

NHS Gloucestershire CCG takes responsibility for Quality Assurance by holding providers to account for the delivery of contractual obligations and quality standards. We also take our own responsibility as system leaders seriously and offer training and development opportunities to facilitate service improvement.

Learning, Development, and Service Transformation

The very successful 'Hot Topics in Health and Social Care' conference ran for a third consecutive year and was organised by the Quality and Nursing Directorate.

This conference is for care givers from across community settings and upskills them in a wide range of topics, including key training on the awareness of pressure ulcers and infections, with an emphasis on infection prevention and control.

Primary Care

The Health and Social Care Act 2012 S26 (14S) also places a responsibility on the CCG to support primary medical services to continually improve.

Over the course of the last year, the CCG has worked with a wide range of GPs to help share learning from Care Quality Commission (CQC) inspections, celebrate success and where needed provide additional support to improve care.

Within the Quality team are a number of independent prescribing clinical pharmacists, who work in GP practices to support GPs by providing expert knowledge and advice relating to medicines and help reduce the pressure in surgeries.

During 2018/19, the CCG Medicines Optimisation Team successfully bid to be included in the national Medicines Optimisation in Care Homes (MOCH) scheme. As part of this exciting initiative, the CCG has a number of specialist pharmacists offering support to care homes and other organisations to improve co-ordination and quality of the medicines management.

The last annual report described the operation of the Prescription Ordering Line (POL). This service continues to provide patients with a dedicated phone line to call to request their repeat prescriptions.

The team of call handlers process the requests on behalf of the patient's registered GP practice, and the prescriptions are sent electronically to their chosen pharmacy.

Patients have commented that they like being able to request their repeat prescriptions over the phone, instead of having to drop off a request at the GP surgery. This service also saves administrative time at both surgeries and pharmacies, as well as helping to reduce wasted medicines by ensuring that medications are not ordered if not necessary.

23 practices are now using the service (and many more have expressed an interest), and currently the service is available to a patient population of c.220,000.

The team currently handle over 9,000 calls per month, and these numbers continue to grow as the service continues to prove to be increasingly popular amongst patients and carers who have used it.

Dieticians

The Quality Team includes CCG employed dietitians to provide GP practices and other community healthcare professionals, including Care Home staff, with nutritional guidance for their patients.

This includes advice on the nutritional management of conditions such as malnutrition, frailty, diabetes, high blood pressure and swallowing difficulties.

Dietitians are uniquely qualified to use the most up to date public health and scientific research on food, health and disease, which they translate into practical guidance to enable people to make appropriate lifestyle and food choices. By supporting patients to choose the right food and drink for them, Gloucestershire can maximise effective treatment of these conditions and help people to live as healthily as possible.

Infection Prevention and Control

In 2018/19, the CCG led the implementation of countywide action plans to reduce Clostridium Difficile and E-coli Infections; including having the processes in place to provide assurance.

Reducing urinary tract infections has been a focus and the CCG has led on hydration projects completed in conjunction with partners from the CCG funded NHS Information bus across the county.

Working together with local public health services a quick response plan was put in place following a slight upturn in the number of MRSA cases amongst a small number of intravenous drug users.

Since this plan was put in place, no further cases have occurred in this group. Further work on the prevention of Measles in young adults was undertaken in partnership with GP Practices. GP Practices sent a personalised letter out to young adults who had never received a MMR vaccination or had only received 1 MMR vaccination encouraging them to have the full course of the available vaccination.

Seasonal Flu

The CCG led a local collaborative approach for the management of flu in the winter of 2018/19; this included a focus on the seasonal Flu vaccination programme.

As a result of hard work and determination from across the ICS locally, we achieved Flu vaccination rates above the England average for all eligible population groups and much higher for 2 and 3 year olds.

An important part of this work was the information shared using social media (targeted approach with video content). The joint collaborative work across the NHS ensured that there were no significant outbreaks of community acquired infections including flu this winter.

The Quality Team has worked together with the local and regional Public Health teams and other organisations this winter to run a pilot project for 'Point of Care Testing' for seasonal flu in care homes. In this pilot, a resident can have a swab taken and the test result obtained quickly at the bedside giving faster information for making decisions about treatment and to help to keep residents at home.

Safeguarding

The CCG Safeguarding Team aims to recognise, endorse and promote safeguarding children and adults at risk of abuse and neglect, with parity and high priority, when commissioning health services across Gloucestershire.

We understand our shared responsibility and are committed to seeking assurances of effective safeguarding from across the health partnership.

Through the CCG's key leadership roles, we ensure a clear line of accountability and the provision of clinical expertise and strategic advice.

The CCG is represented at all Partnership Boards throughout the year by the CCG's Executive Nurse, as well as at Strategic Management and Subgroup levels by Designated Professionals, the Named GP and the CCG's Specialist Nurse for Safeguarding.

In addition, the Safeguarding Children's legislative reforms of Children Act (2004) and Working Together (2018) has an active leadership commitment from both the CCG's Accountable Officer and the Executive Nurse.

We will continue our innovative work that supports engagement and collaboration with colleagues in Primary Care through regular successful forums for GPs and Dental Safeguarding Leads.

The CCG leads the Strategic Safeguarding Health Group for Children and Adults, which includes membership from all local NHS providers. The group facilitates information sharing and the development of professional practice for Named Leads in Safeguarding.

Collaborative working with Health Providers

Over the last year, the CCG has continued to challenge smaller healthcare providers to aspire to even higher quality standards. The CQUIN schemes applied to health providers were, in the main, achieved and as a system we saw staff flu vaccination rates rise with a heightened awareness of staff experience leading to improved care for patients.

The Ambulance Service faced a challenging year and although some of the lower acuity targets were not achieved their focus on the most unwell patients has meant that they were able to deliver excellent care to those most in need.

The joined up approach of both Quality and Commissioning managers from across the South West has helped work across systems to support ongoing improvement work. As new ambulances and a variety of other improvements are introduced our aspiration is to change the current transactional approach to the contract to focus on service improvement.

In Non-Emergency Patient Transport Services (NEPTS), the CCG has worked with colleagues in Bath and North East Somerset, Wiltshire and Swindon CCGs to improve standards for patients travelling with the current provider, Arriva. We have introduced new schemes aimed at ensuring those with a real need for NHS funded transport are able to access a good quality service, while those who are able to make their

own way to hospital are supported to do this. CCG Quality colleagues have also engaged with community transport providers who play an increasingly important role and will continue to do so in the coming year.

As we move to bring NHS 111 and Out of Hours provision closer together we have reviewed quality standards to make measurements more meaningful and reduce the burden of reporting on providers so that they can focus on delivering the highest quality of service.

Going forward, we will continue to do this by aiming to reduce avoidable admissions and ambulance calls.

In the Acute Trust, we have worked across the organisation to drive improvements in Quality and Safety. CCG Quality colleagues are partners in key meetings where a culture of openness and transparency prevails and key relationships are nurtured as we seek assurance for Gloucestershire residents.

Expertise from the CCG is frequently called upon to support service development and in times of escalation. The ICS is now in a good position with all three of our local NHS providers rated as 'Good' by the Care Quality Commission. In addition the overwhelming majority of GP practices and Care Homes are either rated as 'Good' or 'Outstanding'.

Engaging people and communities

This year we have continued to deliver our strategic engagement principles to promote 'Equality' and working in 'Partnership' to enable 'Anyone and Everyone' to have a voice.

Since NHS Gloucestershire CCG was formed five years ago, we have aspired to ensure that the 'quiet voices' are heard and that we are recognised as 'commissioners on the ground'.

Building on these ambitions, our current Clinical Chair, Dr Andy Seymour, recognises that the CCG 'values and seeks to learn from the experiences of everyone involved in promoting, delivering and receiving health, wellbeing and care in Gloucestershire'.

The CCG Constitution reflects the accountability between the CCG and member practices and is supported by appropriate strategies to maintain quality, safety and effectiveness. In turn the Constitution upholds the principles of patient and public engagement which are adhered to by the CCG Engagement and Experience Strategy: 'Our Open Culture'. The CCG constitution is published on the CCG's website at: **www.gloucestershireccg.nhs.uk/wp-content/uploads/2014/07/Constitution-January-2016.pdf**

The CCG Constitution describes how the CCG demonstrates its accountability to its members (GP practices), local people, stakeholders and NHS England in a number of ways. Of particular relevance to Engagement and Experience are the following:

- appointing independent lay members and other healthcare professionals to its Governing Body
- holding meetings of its Governing Body and Primary Care Commissioning Committee in public (except where the Group considers that it would not be in the public interest in relation to all or part of a meeting)
- meaningful engagement, communication and consultation with the population of Gloucestershire
- complying with local authority health overview and scrutiny requirements
- meeting annually in public to present its annual report (which must be published)
- having a published and clear complaints process; and
- complying with the Freedom of Information Act 2000.

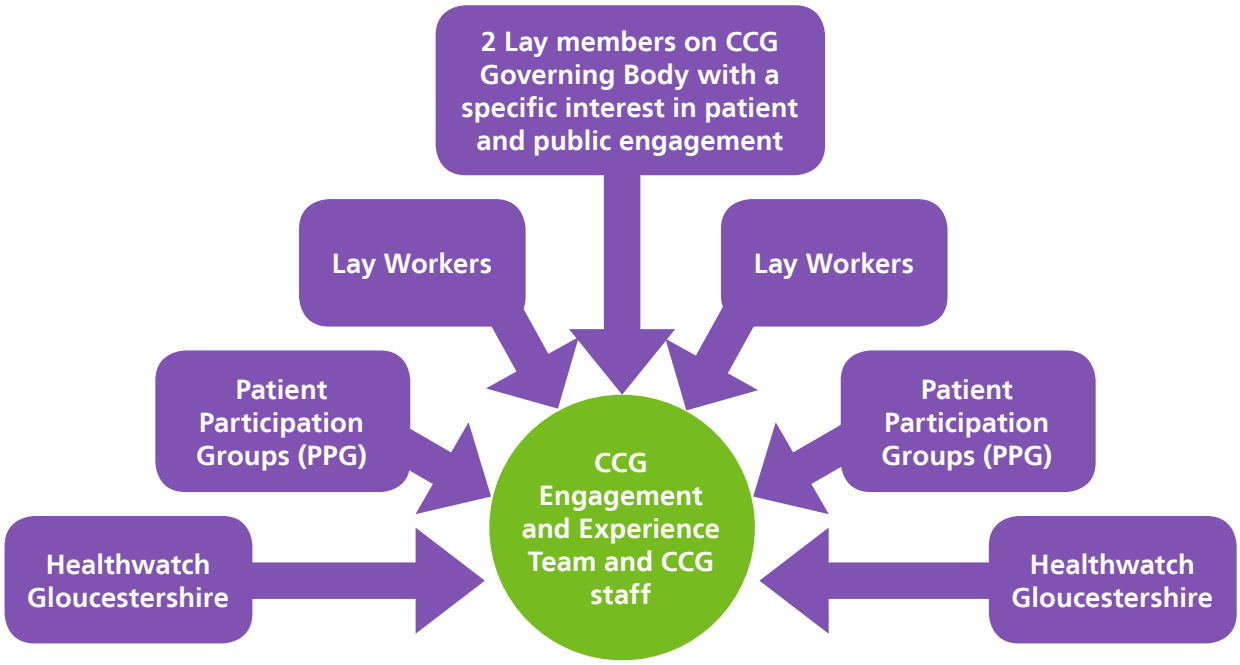
The Engagement and Experience Strategy's aim is to ensure that the CCG achieves the essential conditions and culture within the organisation to make effective engagement a reality and to ensure that the individual's experience of care is a driver for quality and service improvement. The Strategy is available on the CCG website at: **www.gloucestershireccg.nhs.uk/about-you/**

Working in partnership

The CCG is a key partner in the local Integrated Care System (ICS): One Gloucestershire. We work closely with local providers of NHS funded services, strategic partners in statutory agencies, such as county and district councillors and the emergency services, as well as the voluntary and community sector.

At all levels of the organisation from the Governing Body to focused working groups, local people's (lay) voices are heard alongside those of clinicians and managers, when we are planning, developing, procuring, evaluating and monitoring services.

The following diagram shows the structures we have in place to enable local people's voices to be heard within the CCG in order to inform CCG planning, commissioning intentions and decision making.



Supporting people to get involved

To support wider engagement, we want to ensure that local people, if they wish to participate, can be individually or collectively involved in the decisions that are made by us.

In line with our duties under the Equality Act 2010, we continue to build upon existing mechanisms for engagement and establish new ones, which allow everyone who has a stake in healthcare services to have the opportunity to have a voice. This can range from the information we publish in alternative flexible formats, to the activities we invite people to take part in. The CCG is committed to ensuring equality is considered in all service review and redesign, and in the development of our plans and policies. An Equality Impact Assessment is completed for all work programmes that require Governing Body, Quality & Governance assurance.

The CCG has also completed an informal assessment against the NHS Equality Delivery System (EDS2), and is currently planning the involvement of our community partners in this work.

For effective involvement, people need to feel supported, and for their contribution to be valued. In valuing the contribution of stakeholders, the CCG recognises that it needs to remove the financial barriers that can prevent participation. Patients and public should not be out of pocket as a result of their involvement with the CCG so reasonable expenses will be reimbursed. We always include a FREEPOST address when we design 'pull out and return' surveys in printed engagement and consultation materials.

To support patients, carers and the wider public who are involved in helping it shape the development of health services this year, the CCG has developed a more formal Reward and Recognition Policy based on NHS England good practice guidance and policies in neighbouring CCG areas:
www.gloucestershireccg.nhs.uk/your-views/

Meaningful engagement, communication and consultation with the population of Gloucestershire

The CCG is committed to the coproduction of service transformation with the public. For us engagement consists of three levels of engagement, which describe a continuum from activities associated with responding to an individual's experience of care through to formal public consultation. Examples of engagement and consultation undertaken during 2018/19:

Insight Survey

As part of engagement activity to support the development of our local Sustainability and Transformation Partnership/Plan in 2016/17, over 100 local people signed up to be involved in the shaping of local services though an Insight Survey. This enables us to collate information about how people want to participate and the areas they are interested in.

For example, this year a group of local residents have come together, with local NHS managers and clinicians, to co-develop potential solutions for the transformation of urgent care services in Gloucestershire in response to national requirements and local priorities.

Community Hospitals in the Forest of Dean – A Citizens' Jury

Since September 2015, a range of engagement activity has been undertaken to gather feedback from Forest of Dean residents regarding their health and care needs now and into the future. This feedback has informed the development of options for community hospital services in the Forest of Dean, leading to a period of consultation on a preferred model for the future last year.

The decision was made in January 2018 to build a new community hospital for the Forest of Dean, which would ultimately result in the closure of the Dilke Memorial and Lydney and District Community Hospitals.

In response to consultation feedback and the recommendations in January 2018, the CCG and Gloucestershire Care Services NHS Trust (GCS) jointly appointed Citizens Juries Community Interest Company (CIC) to run an independent citizens' jury. Citizens Juries CIC is a social enterprise dedicated to designing and running citizens' juries, supported by the University of Manchester. It works in partnership with the Jefferson Centre, the US-based charity which developed the citizens' jury method.

The Jury was asked to consider information and make a recommendation regarding the location of the new hospital for consideration by the CCG Governing Body and the Board of GCS.

The jury met for four and half days at the end of July 2018 to consider the best location for the new community hospital in the Forest of Dean. The Jury was made up of 18 local residents who were recruited, by Citizens Juries CIC, to ensure a balance in terms of age, gender and geography.

The information and evidence presented to the Citizens' Jury was reviewed by an independent Oversight Group, selected by Citizens Juries CIC. The three members of the Oversight Group represented Healthwatch Gloucestershire, Forest of Dean District Council and the Voluntary and Community Sector Alliance.

An independent equality impact analysis on the potential location of a community hospital in the Forest of Dean was commissioned and presented to the Jury (and subsequently to GCS Board and the Governing Body of the CCG).

Three themes in particular emerged during this period of engagement:

- the relationship between where survey respondents state they live and where they think the new hospital should be located
- concerns and comments in relation to public transport and access; and
- a range of views relating to a central location in the Forest of Dean.

A full Outcome of Engagement Report is available at **www.fodhealth.nhs.uk**

The recommendation of the jury was presented to the CCG Governing Body and GCS Board meetings in August 2018. Governing Body members were impressed by the conscientious approach taken by the Jury and, having reviewed all of the evidence, endorsed their recommendation to build the new hospital in, or near, Cinderford.

The involvement of local people through the Citizens' Jury was supported by Healthwatch Gloucestershire, Health and Care Overview & Scrutiny members, Hands off Dilke & Lydney (local lobbying group) and the wider community.

The process attracted the attention of local media and has been the subject of much review. The CCG consider the process to be a robust mechanism, which empowers members of the local community and gives them a voice at the very highest level of decision-making. A full copy of the Citizens' Jury report, together with our Governing Body papers is available at **www.fodhealth.nhs.uk**

In addition to the recommendation regarding the location of the new hospital, the Citizens' Jury made some supplementary recommendations:

- Improving transport accessibility options for communities throughout the region and ensuring accessibility for drop-offs, transfers, and other transport needs
- Considering how to incorporate on-site amenities (such as a cafe or a chemist) to maximise the benefits of the new hospital
- Ensuring that a full range of necessary and suitable services are provided and that the new hospital is adequately staffed
- Planning for future use and needs of the entire Forest of Dean in the design and size of the building.

The CCG and GCS committed to ensuring these recommendations are fully considered by the relevant Programme Board. A commitment to continue to engage with the local community as the project develops was also given.

Frailty Information Bus and Frailty Wheel

The CCG used its Information Bus to host a frailty roadshow around the county, providing resources to increase knowledge and confidence in managing frailty. The specific areas visited by the Bus were chosen to reflect SWAST data regarding the highest admission rates for people with frailty and population health data: Cirencester, Stroud, Bishops Cleeve, Coleford, Cinderford and Lydney. Further venues will be booked for 2019.

The roadshows specifically targeted people with disabilities and long-term conditions, and their families and friends. Over the six sessions, the bus had representation from a large number of organisations/ providers: Carers Gloucestershire, Age UK, Telecare, Community Wellbeing Services (GRCC & Independence Trust), ²gether NHS Foundation Trust, Shared Lives and the Fire Service in addition to CCG and Council staff.

Having a clinician on board was beneficial as we were able to offer blood pressure checks, which was popular and gave the opportunity to talk about improving wellbeing. The bus helped the CCG and partners to engage with those who had concerns about family members or wanted to start thinking about themselves or family members own health and wellbeing and what they could do to prepare for the future.

LGBT Partnership Cheltenham/Time to Talk Day

Time to Talk Day 2019 provided the perfect opportunity to work in partnership with ²gether NHS Foundation Trust and the LGBT+ Partnership Cheltenham on this awareness-raising event in the town centre.

Mental health problems affect one in four of us, yet people are still afraid to talk about it. Time to Talk Day encourages everyone to talk about mental health and challenge stigma.

The event provided the perfect opportunity to hold a combined event, with a common goal of breaking down barriers and reducing stigma.

The event built on the developing working relationship between ²gether NHS Foundation Trust and the LGBT Partnership, but brought in other partners from the CCG and University of Gloucestershire. A range of materials were made available at the day: the CCG provided an eye-catching banner to promote the event that was suitably generic to support other events with the LGBT Partnership.

As a result of this engagement we are now planning to support the LGBT Partnership to reach local communities at a number of high profile events this year including Gloucester Pride and Cheltenham Pride.

We are also meeting members to discuss our "what matters to you?" engagement relating to the NHS Long Term Plan, ensuring that the voice of our LGBT community is represented in the development of our future services.

Supporting the development of Primary Care estate

Across England, 40% of GP practices surveyed by the British Medical Association felt their premises were not adequate to deliver existing services and 70% were too small to deliver extra services.

Against this backdrop, the CCG recognised the need to ensure sufficient local capacity for the future, whilst maximising the use of the county's existing facilities and delivering value for money.

With a focus on enhancing patients' experience and improving the environment for staff to provide the best care, GCCG commissioned an estates survey in the Spring of 2015, which highlighted constraints in some buildings: the condition of some buildings was no longer suitable for the long term; others presented challenge due to the functionality, or existing layout. At this stage there were a number of committed developments and improvements underway in Gloucestershire, but a structured programme to improve the quality and capacity of primary care buildings was subsequently developed.

In respect of a proposed primary care premises development, the CCG sees two key stages when practices should be working with their patients and communities:

- Engagement during the completion of a business case where options are being considered
- Following approval, continued engagement through the detailed design and construction period.

During 2018/19 the CCG's Patient Engagement Team has supported a number of practices to engage their Patient Participation Groups (PPGs) and wider practice population. This support has included:

- the facilitation of patient surveys/feedback forms and reporting on feedback received
- supporting engagement events which provide an opportunity for patients to view and comment on plans and proposals; and
- liaison with local stakeholders and elected representatives.

One example is the engagement undertaken by Forest Health Care and Dockham Road practices in Cinderford.

Both practices are finding it increasingly difficult to provide high quality services from their existing site and were looking to develop new premises. Working with the appointed developers, both practices invited their Patient Participation Group (PPG) members to a joint meeting. At the meeting, members took part in a site options appraisal that reviewed a number of potential sites around the town. They reached consensus on a preferred site and their feedback was used to inform the final decision making by the practice partners.

PPG members subsequently supported drop-in events for patients and the wider community and continue to be involved in the project as progresses. Over the coming months, we will continue to support practices to engage patients in projects that improve and/or redevelop their premises. It is important that the PPE team is involved in the early stages of these projects, and in recognition of this we will be enhancing the PPE toolkit available to practices.

End of Life Clinical Programme Group

The End of Life Care Clinical Programme Group (CPG) was created 18 months ago to deliver the priorities set out in the End of Life Care Strategy 2016/19.

This strategy made a commitment to ensure the highest quality end of life and palliative care services are available to all who need it irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation and socio-economic status.

Integral to any service improvement or re-design work is listening to people with experience; this is particularly true in relation to end of life care services. Dame Cecily Saunders, the founder of the Hospice movement, said "How people die remains in the memory of those who live on".

We will only die once, which means there is only one chance to ensure people, and those closest to them, have a 'good' experience at the end of their life and in death.

To support the delivery of the End of Life Care Strategy the CPG decided to recruit two people with experience (they cared for loved ones who died in Gloucestershire) along with a Healthwatch representative, to be members of the End of Life Care CPG.

The first two CPG meetings were workshops that explored what a 'good' experience of end of life care might look and feel like for people, their carers and families. In these workshops, patient representatives were able to share their experiences, both good and bad, with health and social care professionals.

An End of Life Care programme of work, with many service improvement projects, was developed following the workshops.

Patient and Healthwatch representatives are included on many of these projects as part of the Project Team. They choose which projects they want to be involved with, usually as a result of their individual experiences, where they feel they will most add value and make a difference, for example:

- Involvement in a project to record and share electronic DNACPR (Do Not Attempt Resuscitation) and other end of life care preferences, to prevent inappropriate resuscitation. This was because a person they cared for was so worried about being resuscitated against their wishes they wrote DNACPR on post-it notes and stuck them around their bed and throughout the house in case emergency services were called;
- Involvement in the project to roll-out anticipatory (or 'Just in Case') end of life care medication because the person they cared for wasn't able to access timely pain relief when it was needed.

Of particular note was a project supported by patient representatives but more extensively, by Healthwatch.

The CPG wanted to understand what holistic (non-clinical) support at end of life was available locally and what people thought was needed (i.e. where the gaps were). Healthwatch Gloucestershire undertook a range of engagement exercises (including a survey) with people who were caring for, or who had cared for, people at end of life. The resulting report was published on their website:
www.healthwatchgloucestershire.co.uk/reports-publications/

The Healthwatch engagement work contributed to the final report from the holistic support project. The key themes emerging were:

- Information in the same place where it is easy to find and navigate
- Information on the physical changes at the end of life and what carers and families might expect
- Psychological and emotional support available to carers/family as well as patient

- Post death practical advice and bereavement support (not just immediately after the death but ongoing to help the person cope with loneliness etc.)
- Even when information is given it may not always be taken in or remembered at a time when people are in such stressful and upsetting circumstances.

The CPG has developed leaflets offering good practical advice including information about the physical changes which might be expected at the end of life, but feedback indicated that these are not being accessed by those who may have benefitted from them.

The CPG will, therefore, undertake a review of where we are locating copies of the leaflet and how we can ensure these are more accessible; and how we can raise awareness of this information amongst professionals.

Future in mind – 2018/19 refresh

Our Vision: *'Children and young people of Gloucestershire thrive and grow up to be confident and resilient individuals'*

Gloucestershire's Future in Mind 5 Year Transformation Plan for Children and Young People's Mental Health was developed with a range of local stakeholders including children and young people.

The plan takes a whole systems approach to prevention, provision of information and advice; and early intervention through to crisis support.

The aim of the Plan refresh was to reflect local progress with transforming the system of support for children and young people, and identify further ambitions based on our local developing work in this important area.

A workshop was held in August 2018 with young people to test the work undertaken against priorities identified through previous engagement ensure and to help identify emerging priorities for inclusion in this year's refresh.

14 young people attended: they were asked to provide their views, feedback and opinions throughout the duration of an informal workshop. Feedback was also sought through the Children's Emotional Health and Wellbeing Partnership: a group of local key stakeholders from across children's services, including health, education, schools and third sector organisations.

"You said – We Did"

The session was designed to enable us to revisit the key elements and priorities for future services identified by children and young people during engagement in 2015 for the original plan. Young people were asked to connect speech bubbles with the aforementioned statements on to puzzle pieces which detailed work being done or completed within health and social care.

We wanted to test whether the local priorities of children and young people, identified in 2015, have been met through existing/planned programmes of work. It was apparent from the exercise that young people were able to clearly identify links between priorities and new services or facilities commissioned in response to the issues raised.

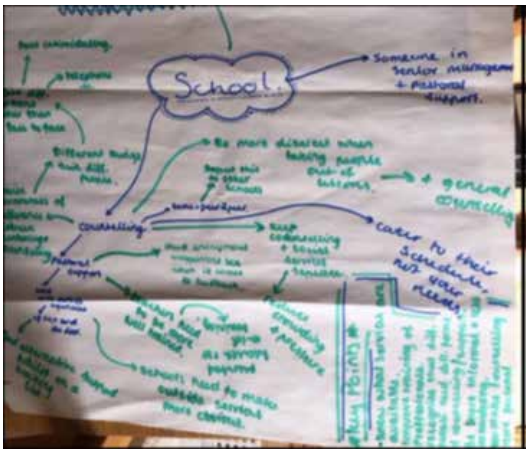
It was however noted that many of the young people present were not familiar with the 'On Your Mind' website and welcomed watching the online video to understand more about the resource: **www.youtube.com/watch?v=PBhx2JceJJI**

"Support in Schools"

We wanted to know whether young people are aware of what work is being done in schools, any changes they may have noticed or experienced recently and what could be done better or developed further.

The young people discussed their experiences and agreed the following key themes:

- School Nurses need to be upskilled in Mental Health First-Aid
- More discretion is needed to help the most vulnerable
- There needs to be multiple access methods – not one size fits all e.g. Face to face, telephone, text, website information
- There should be practical or informative sessions to inform all children, not just those with a medically diagnosed condition – normalise mental health!



Primary Care Patient Advice and Liaison Service

The number of contacts to CCG PALS has steadily increased during 2018/19, with just over 800 people contacting the service – a rise of almost 25%.

PALS Case studies are a routine feature of Quality Reporting to the CCG Integrated Governance and Quality Committee.

Patients acknowledge that PALS intervention has helped them and they say they have felt supported at an earlier stage, negating the need for formal complaints to be made.

Opportunities in 2019 to be explored include introduction of a more systematic evaluation of the experience of users of the PALS service and collection of more detailed demographic information about those individuals who proactively access the service, based on the NHS England Surveying complainants Toolkit: **www.england.nhs.uk/surveying-complainants/**

This will enable us to develop targeted communication and promotional materials to reach groups which may currently not be aware of, or are choosing not to access, the service.

Patient Participation Groups (PPG)

www.gloucestershireccg.nhs.uk/about-you/patient-participation-groups/

From April 2016, it has been a contractual requirement for all English GP practices to form a Patient Participation Group (PPG). The CCG offers proactive and reactive support and advice to Practices and PPGs to support their engagement.

In Gloucestershire, the CCG facilitates a Network of active PPGs who meet together on a quarterly basis. The PPG Network was established to provide a regular forum for PPGs from approximately 75 GP practices to come together to receive information, to share learning and to network, all with the purpose of improving patients' experience of primary medical services in Gloucestershire.

Gloucestershire PPG Network considers the National GP Patient Survey (GPPS)

For the past two years, PPG members have received an annual presentation on GPPS. The first year's presentation, made by the CCG's lead for engagement and experience, who is a member of the National GPPS Steering Group, focussed on the CCG's overall performance and encouraged PPGs to go back to their individual practices to discuss their local results with the practice team to identify areas for improvement focus, for example, suggesting ways the GPPS practice comparison tool could be improved to make it more helpful to PPGs.

This year's (2018) presentation, made by members of the NHS England national GPPS team, again looked at the CCG's overall results, but also provided a live demonstration of the GPPS analytical tool. The presentation focussed in particular on the changes to GPPS in 2018 and the rationale for the changes. PPG members were encouraged to take part in a lively Q&A session and provide feedback to the national team about potential improvements to the GPPS for next year.

The PPG Network has been a great way for the CCG to engage PPGs in using survey data. Following the presentation and live demonstration of the analytical tool by the national NHSE GPPS Team, PPGs took away an increased understanding of how to use the survey data more, as well as about the running of the survey.

The CCG continues to play a strategic role in the development of the GPPS through its membership on the national GPPS Steering Group. The CCG looks forward to seeing the publication of this year's results this summer and sharing these with the PPG Network and individual practices in 2019/20.

Graphic Facilitation

Graphic Facilitation (or Graphic Recording) is an engagement tool for producing real time, live graphic records. Use of this tool has been developed in 18/19 to support our engagement approach.

Graphic recording provides an accurate record of key ideas synthesised and documented into a visual form rather than a traditional minute form. Many people are visual learners, and studies indicate that people remember more information when combined with visuals than via spoken word alone. Graphic recording can therefore increase engagement and memory-retention for the audience and can be displayed in office spaces as a reminder of the ideas uncovered and the commitments made during the meeting or event.

Furthermore, they can be formalised and presented in clinical settings such as hospital wards to help inform the public on upcoming priorities or ideas. Once the product is finished, the recording can be digitalised for sharing to ensure the co-produced output is shared.

In particular, maternity services have recognised the value of using this method to capture new parents' views.

Graphic Facilitation was used to capture the output of the Gloucestershire MindNBody Whose Shoes Workshop in May 2018. The event was held at Kingsholm, Gloucester Rugby Club in Gloucester, on 24 May 2018. It provided an opportunity for anyone who had become a parent within the last five years to talk about mental health difficulties they experienced and help shape enhanced support for others.

The South West Maternity Clinical Network funded a graphic facilitation course following the success of the Whose Shoes Maternity events across the region. Limited free training places were offered to South West sites and Gloucestershire secured three places.

Future Plans 2019/20

Early this year, we welcomed publication of the national 10 year Long Term Plan for the NHS, which is consistent with how support and services are developing locally. The plan highlights the ambitions to make sure everyone gets the best start in life, to deliver world class care for major health problems and support people to age well. The plan acknowledges there will be challenges along the way across the country.

The Gloucestershire Integrated Care System 'One Gloucestershire' is planning a series of phased engagement and consultation activities

to support the development of our local response to the LTP, beginning in March 2019. We are asking local people 'what matters to them? (and why?) about local health and care as we develop our NHS Long Term Plan for Gloucestershire.

Reducing health inequalities

Health inequalities are the preventable, unfair and unjust differences in health between groups, populations or individuals caused by unequal social, environmental and economic conditions within our society.

These determine the risk of people getting ill, their ability to prevent sickness or opportunities to take action and access treatment when ill health occurs.

Reducing the health inequalities within Gloucestershire is viewed by the CCG as a key factor in any decisions we make.

To try to reduce health inequalities we created our Prevention and Self-Care Plan. This sets out our vision to ensure prevention is embedded across our health system and focussed on giving individuals and communities' greater control of their health and wellbeing.

Reduction of health inequalities is a central consideration to all the work we are undertaking to deliver on this plan. Many of our projects are delivered in a way that targets specific areas and groups with the aim of reducing known inequalities, for example during 2018/19 we recruited three GP inequality fellows to specifically work within Gloucester City to reduce health inequalities.

It is clear that to tackle health inequalities we need to work with all our partners across the system to take action in a coordinated way. Our Enabling Active Communities work has brought together colleagues from across the health and care, voluntary, community, charity and social enterprise sectors to work together to improve the health of our population.

This work has produced a more collaborative environment across the wider system, work which we intend to build on and further develop in our future plans.

During 2018/19 we have seen more than 3,000 people in our Community Wellbeing Service, working with them to help them take control of their own wellbeing and connecting them with local groups and charities that are able to help.

Health and Wellbeing Strategy

The Gloucestershire Health and Wellbeing Board oversees the development and delivery of the Joint Health and Wellbeing Strategy, with an aim of improving the lives of people in Gloucestershire.

The priorities include healthy lifestyles and supporting communities top take an active role in improving health.

The CCG is an active member of the health and wellbeing board and works with partners to deliver the Joint Health and Wellbeing strategy.

The current Health and Wellbeing strategy is being refreshed with a view to producing a new strategy during 2019/20. This will see a renewed focus and commitment to deliver improved health and wellbeing outcomes for the people of Gloucestershire. The strategy will be delivered with our partners and public across the entire county.

Although the strategy is being refreshed, work to improve the health and wellbeing of people in Gloucestershire has continued during 2018/19.

Over the last year, the CCG worked with partners from across the health and care system to take action focussed on prevention and wellbeing. We have built on the learning from last year to improve our approach with a view to delivering the very best outcomes for the public in Gloucestershire.

Some examples of the work we are doing, in line with the healthy lifestyles priority, include our healthy weight work, one aspect of which has seen us working closely with families across Gloucestershire to develop a children and young people's weight management service. This service will 'go live' during 2019/20.

Working with partners, we have also continued our 'Gloucestershire Moves' physical activity programme. This programme is aiming to make being physically active the new normal in Gloucestershire. Under this programme we delivered a 'Beat the Street' game over the summer of 2018 which saw more than 10,000 people take part and get out and about in their local community.

Constitution standards – performance 2018/19

Our aim is to ensure Gloucestershire patients have high quality and timely care.

We work collaboratively with our providers to meet the standards that are expected by patients and are set out in the NHS Constitution. The CCG, through its Governing Body, monitors progress against these targets and is responsible for countywide performance against these measures.

2018/19 has continued to be a challenging year nationally with regard to performance against NHS constitutional targets, and this has been the case in Gloucestershire as well.

However, there are several areas where performance has improved compared with previous years, in particular around the provision of psychological therapy for anxiety and depression, reducing delays in discharging patients from hospital and response times for the most clinically urgent emergency ambulance responses.

Adherence to key cancer waiting time targets is also improving, with shorter waits for patients to be seen or receive their first test following referral with suspected cancer. While still below target, time to first treatment for all diagnosed cancer is reducing, and where the referral is from a screening programme the treatment target is met in full.

Provision of diagnostic tests within 6 weeks of referral has also improved, meeting the national standard monthly throughout the second half of 2018/19 and meaning that patients are waiting less time for these tests.

Urgent care provision is particularly under pressure and the national 4 hour target (to see and treat or admit 95% of patients within 4 hours) has not been met either nationally or locally in 2018/19.

A summary of where Gloucestershire has met the NHS Constitution targets fully is shown below:

	2018/19 Status	2019/20 forecast
Cancer – at least 94% of patients to receive subsequent treatment for cancer within 31 days of diagnosis – surgery	Green	Green
Cancer - at least 98% of patients to receive subsequent treatment for cancer within 31 days of diagnosis - Drug Regime	Green	Green
Cancer - at least 94% of patients to receive subsequent treatment for cancer within 31 days of diagnosis - Radiotherapy	Green	Green
Cancer - 62 day wait for first treatment following referral from an NHS cancer screening service	Green	Green
Cancer - Two week wait for breast symptoms – At least 93% of patients seen for the first time within 2 weeks of referral	Green	Green
Dementia Diagnosis rate – at least 2/3 of people aged over 65 with dementia receiving a formal diagnosis	Green	Green
IAPT Recovery rate – at least 50% of people with anxiety and depression making a recovery following treatment by an "Improving Access to Psychological Therapies" service	Green	Green
Delayed Transfer of Care (to be below 3.5% of all occupied beds)	Green	Green

Despite these successes, and improvement throughout 2018/19, there are targets that the CCG has struggled to achieve, and will remain a focus for improvement throughout 2019/20:

	2018/19 Status	2019/20 forecast
The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period to be more than 92% (Referral to treatment – RTT)	National Reporting Suspended	Return to national reporting
Ambulance Category 1 (urgent life threatening call) average response time to be less than 7 minutes	Amber	Green
Cancer – All cancer 2 week waits – At least 93% of patients seen for the first time within 2 weeks of referral	Amber	Green
Cancer – at least 96% patients to receive first definitive treatment within 31 days of a cancer diagnosis	Amber	Green
Referral to Treatment pathways incomplete at greater than 52 weeks (zero tolerance)	Red	Amber
Cancer – 62 day cancer treatment target (percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer to be greater than 85%)	Red	Amber
Cancer – 62 day cancer treatment target (percentage of patients receiving first definitive treatment for cancer within 62 days of consultant referral for suspected cancer to be greater than 90%)	Red	Amber
Mixed sex accommodation breaches (zero tolerance)	Red	Green
Diagnostic test waiting times – not more than 1% patients having to wait over 6 weeks for diagnostic test	Amber	Green
IAPT Access Rate – at least 19% of people with anxiety and depression accessing an "Improving Access to Psychological Therapies" service	Amber	Amber
Although we haven't achieved the national access target we have ensured that 17% of people with anxiety and depression have been able to access IAPT services thus meeting our local target.		

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

Referral to Treatment (RTT): Due to the implementation of a new electronic patient administration system reporting against the national RTT target has been suspended during 2018/19. The CCG continues to monitor long delays for patients waiting for treatment with monthly performance meetings with Gloucestershire Hospitals NHS Foundation Trust (GHFT) where any breaches of 52 weeks are discussed. We are expecting GHFT to begin reporting RTT nationally again in 2019/20, and improvement in RTT is a priority for the whole Gloucestershire system to ensure that long waits for patients are minimised.

Where Gloucestershire patients are seen and receive their treatment at out of county providers, the CCG is provided with assurance that all patients who are delayed have been clinically reviewed.

Performance management is being undertaken in conjunction with the lead commissioner for planned care, through the access and performance meeting.

For the provider Trusts where we are an associate commissioner, we receive the monthly performance position highlighting the issues and have an opportunity to challenge progress.

4 hours emergency department wait: The local target has been met throughout 2018/19 (to see and treat or admit 90% of patients within 4 hours at an Emergency Department or Minor Injury Unit).

Despite performance being below the expected national target of 95%, it has improved significantly on previous years and compares well with other areas nationally. In order to support delivery of this target, Gloucestershire has focussed on a number of projects which help spread the demand on urgent care and keep patients moving through the system. In particular:

- Provision of community services as alternatives to A&E and hospital admission
- Improved discharge from hospital to make sure patients are able to go home as soon as they are well
- Improved advice and guidance resources so patients are confident to self-care where appropriate and clinicians are able to direct patients to the right place for treatment first time
- Provision of specialist rehabilitation services to help patients recover more quickly and to a higher level.

Ambulance Response time: Performance against the average response time to Category 1 (life threatening) calls target has much improved in Gloucestershire, with this trend expected to continue into 2019/20. Additional vehicles are being commissioned for 2019/20, which will help to meet the average response time target more consistently across both urban and rural settings.

Diagnostic waits: The proportion of patients waiting over 6 weeks for a diagnostic procedure has improved from the previous year, particularly over the second half of the year, where the number of patients waiting more than 6 weeks for a diagnostic test has consistently remained below 1%. The CCG expects that this improvement will continue in 2019/20.

Cancer waiting times: Delivery of cancer targets remains a countywide focus, with a cross organisational cancer programme group continually working to improve referral pathways and experience for Gloucestershire patients.

Whilst the 2 week wait target has not been met for 2018/19, performance has improved significantly compared to 2017/18, and the 93% target was met in December 2018 for the first time in 20 months.

Performance against the 62 day treatment target continues to be an area of concern, especially in the Urology specialty. The CCG has worked closely with the GHFT and NHS Improvement to agree a plan for recovery, including pathway reviews and additional clinics to minimise delays for treatment.

Mental health targets: The CCG continues to meet dementia diagnosis rates achieving the 66.7% standard in 2018/19 with people with dementia supported by GP practices and ^{2}gt memory clinics.

IAPT Recovery rates are expected to continue to deliver the target of 50% of people recovering in 2019/20, and the service has plans to expand to reach a wider range of people who could benefit from psychological therapy for anxiety and depression.

Quality Premium

The Quality Premium is intended to reward the CCG for improvements in the quality of the services that we commission and for associated improvements in health outcomes and reducing inequalities.

In 2018/19, we were assessed against our targets for 2017/18:

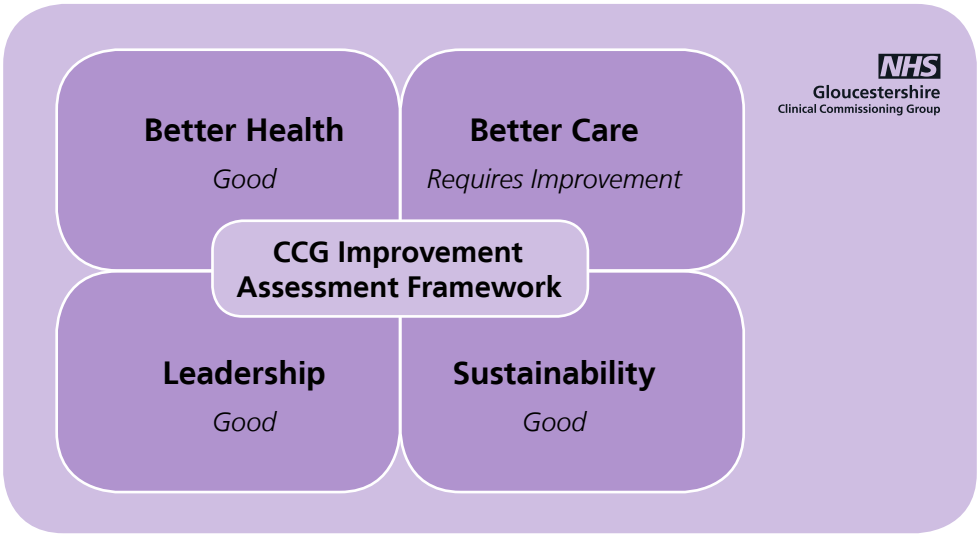
Domain	Description	Achievement
Cancer – Cancers diagnosed at early stage	Demonstrate a 4 percentage point improvement in the proportion of cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2017 calendar year compared to the 2016 calendar year. OR Achieve greater than 60% of all cancers (specific cancer sites, morphologies and behaviour*) diagnosed at stages 1 and 2 in the 2017 calendar year.	Not Achieved
Continuing Healthcare	CCGs must ensure that more than 80% of all full NHS CHC assessments are completed within 28 days. & CCGs must ensure that less than 15% of all full NHS CHC assessments take place in an acute hospital setting.	Partly Achieved (only 0.8% of assessments took place in an acute setting)
Mental Health – A reduction in Out of Area Placements	Total bed days for people sent inappropriately out of area reduce by 33%	Achieved
Bloodstream Infections – reducing gram negative blood stream infections (BSI) across the whole health economy	A 10% reduction (or greater) in all E coli BSI & Collection and reporting of a core primary care data set for all E coli BSI	Partly Achieved (Core dataset established and collected)
Bloodstream Infections – reduction of inappropriate antibiotic prescribing for urinary tract infections (UTI) in primary care	A 10% reduction (or greater) in the Trimethoprim: Nitrofurantoin prescribing ratio & A 10% reduction (or greater) in the number of Trimethoprim items prescribed to patients aged 70 years or greater	Achieved
Bloodstream Infections – sustained reduction of inappropriate antibiotic prescribing in primary care	Items per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR-PU) must be equal to or below 1.161 items per STAR-PU	Achieved
Local Indicator – Improved outcomes for stroke patients	The percentage of applicable patients who go direct to a stroke unit within 4 hours to be above 45%	Achieved

The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights.

CCG Improvement and Assessment Framework

CCGs play a major role in achieving good health outcomes for the population that they serve. NHS England has designed a set of outcome measures (or domains), described below, that help to demonstrate how well an individual CCG is tackling important health outcomes.

All CCGs are assessed on a quarterly basis by NHS England against these domains/indicators based on a standardised framework. NHS Gloucestershire CCG has been rated Good in all areas except 'Better Care' – this domain requires improvement as not all NHS constitutional targets have been met by the CCG this year.



Following development of Integrated Care Systems, the IAF framework will evolve to reflect a population-based approach to improving health outcomes and reducing health inequalities.

Development of this framework will be informed by the long-term plan for the NHS. This will ensure that the ambition described for the NHS is captured in the metrics that are used to assess and oversee CCGs and healthcare systems in the future.

Mary Hutton

Accountable Officer

May 23 2019

6 CORPORATE GOVERNANCE REPORT

Corporate governance report

The Corporate Governance report outlines the composition and organisation of the CCG governance structures and how they support the achievement of the CCG objectives.

It comprises the:

- Members' Report
- Statement of the Accountable Officer's responsibilities
- Governance Statement.

Members' report

Gloucestershire CCG (the CCG) is responsible for planning and commissioning health services for a local registered population of 650,000. The CCG was authorised in April 2013 and operates in accordance with its Constitution (**www.gloucestershireccg.nhs.uk/about-us/the-governing-body/constitution/**) with a governing body comprising clinicians, lay members and executive directors. Dr Andy Seymour is the Clinical Chair of the CCG.

Member Practices

The CCG is a clinically led organisation with *75 GP member practices, organised into 16 clusters and 7 localities. Our member practices help to shape local health services. A listing, by locality, of each of the member practices can be found at: **www.gloucestershireccg.nhs.uk/about-us/localities/.**

**figure for 2018/19. 74 GP practices and 14 Primary Care Networks in April 2019.*

Member profiles

For a list of Governing Body members, their profiles and records of attendance at Governing Body meetings see the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

Committee(s), including Audit Committee

For a list of Audit Committee members and a record of their attendance at meetings see the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**. This also includes details of sub-committees of the governing body and members' record of attendance at meetings.

Register of Interests

The CCG maintains a Register of Interests in line with its Standards of Business Conduct Policy and details set out within its Constitution. The Register of Interests (**www.gloucestershireccg.nhs.uk/about-us/transparency/**) is updated whenever there is a change and posted on the CCG's website quarterly. There are registers of interest for Governing Body members, CCG staff, along with registers detailing any gifts and hospitality received.

In addition, at the start of each meeting of the Governing Body and formal committee meetings, members are required to declare any conflicts of interests in relation to the items on the agenda and discussion is held around how any conflicts have been handled and this is formally recorded in the minutes.

Personal data related incidents

There were no personal data related incidents that took place from 1 April 2018 to 31 March 2019.

Statement of Disclosure to Auditors

Each member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report;
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

The CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking and will be taking an annual Slavery and Human Trafficking Statement as set out in the Modern Slavery Act 2015 to our Governing Body in 2019/20.

Section 54 of the UK Modern Slavery Act (2015) requires commercial organisations that operate in the UK and have an annual turnover above £36m to produce a Slavery and Human Trafficking statement each year.

The statement sets out how a business is taking steps to address and prevent the risk of modern slavery in operations and supply chains. Although the CCG is a public sector organisation, it has taken steps to ensure that its procurement processes have been reviewed in light of the legislation; so that a section on the Modern Slavery Act (2015) is included in the Standard Selection Questionnaires (SSQs) formerly known as Pre-Qualification Questions for companies interested in bidding for health service contracts. This section requires bidders to confirm that they are compliant with the annual reporting requirements contained in s.54 of the 2015 Act.

Statement of Accountable Officer's Responsibilities

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

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

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

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out under the National Health Service Act 2006 (as amended), Managing Public Money and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I also confirm that:

- as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information
- that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

Mary Hutton

Accountable Officer

23 May 2019

Governance Statement

Introduction

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

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

As at 1 April 2018, the clinical commissioning group is not subject to any directions from NHS England, issued under Section 14Z21 of the National Health Service Act 2006.

The CCG is a membership organisation and the provider of primary medical services drawn from seven localities:

- Cheltenham
- Forest of Dean
- Gloucester City
- North Cotswolds
- South Cotswolds
- Stroud and Berkeley Vale
- Tewkesbury, Newent and Staunton.

Practices that provide primary medical services to a registered list of patients under either a General Medical Services, Personal Medical Services or Alternative Provider Medical Services contract are eligible to apply for membership of the CCG.

Gloucestershire GPs have a strong tradition of being involved in the planning and design of services for their patients and are committed to working with patient groups, local stakeholders and partners across the county to put residents at the heart of the CCG's work. Renewed energy has been put into reviewing the CCG's vision and values as well as the Integrated Care System's (ICS) vision and communicating this widely to its member practices, staff and partners.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the clinical commissioning group's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money.

I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

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

Governance arrangements and effectiveness

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

The Constitution of the Clinical Commissioning Group 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 CCG operates in line with the good governance standards including the standards of behaviour published by the Committee on Standards in Public Life (1995) known as the Nolan Principles, the Standards for Members of NHS Boards and CCGs in England (2012) and the seven key principles of the NHS Constitution. This includes the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds, the management of the organisation and the conduct of its business.

The CCG's overarching governance arrangements are set out in its Constitution which explains the powers that the member practices have elected to reserve for themselves as members of the CCG and those that they have delegated to the Governing Body of the CCG and its various committees.

The Constitution describes the governing principles, rules and procedures that the member practices have established to ensure accountability and probity in the day-to-day running of the CCG. It contains the Standing Orders, Standing Financial Instructions and a Scheme of Reservation & Delegation along with the terms of reference for the Committees of the Governing Body.

The CCG uses its Internal Audit function to independently audit its governance arrangements and check compliance with legislative requirements and public sector good practice.

Governing Body – Structure

The Governing Body is responsible for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.

The Governing Body is a mixture of primary care and secondary care clinicians, experienced NHS managers, lay members and local authority representatives. The Governing Body membership can be found on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

Governing Body – Meetings

The Governing Body is chaired by Dr Andy Seymour. It met nine times in 2018/19; three of those meetings were Extraordinary Governing Body meetings organised to take urgent decisions. All meetings were quorate. During the year, the Governing Body approved:

- Arrangements with Aneurin Bevan University Health Board on Cross Boarder Healthcare and agreed the Statement of Values and Principles that underpinned this arrangement
- The location of the Stroke Rehabilitation Unit at Vale Community Hospital, Dursley, Gloucestershire
- The recommendation of the Citizen's Jury of Cinderford for the location of the new community hospital in the Forest of Dean
- The CCG's Strategy for Equality and Engagement called An Open Culture: Engagement – Equality – Experience
- The paper on a Local Commissioning Policy for Wet Age-Related Macular Degeneration
- The CCG's Procurement Strategy 2018-2021 (revised and updated)
- NHS England Emergency Preparedness, Response and Resilience Annual Assurance 2018/19
- Delegation by NHS Gloucestershire CCG to NHS Bristol, North Somerset & South Gloucestershire CCG to exercise functions relating to Excess Treatment Costs arising from Non Commercial Interventional Research.

Governing Body papers are published on the CCG's website and can be found here: **www.gloucestershireccg.nhs.uk/category/board-meetings/**.

Audit & Risk Committee

The Audit & Risk Committee is responsible for the oversight of financial assurance matters and reviews all internal and external audit reports, and has no executive membership.

At the beginning of the financial year 2018-19, the committee took responsibility for risk management, providing assurance to the Governing Body that risk structures, processes and practices are robust and embedded throughout the organisation. The committee receives regular reports on risk management, copies of the Corporate Risk Register (CRR) and Governing Body Assurance Framework (GBAF).

The committee met six times in the financial year 2018-19 and was quorate on each occasion. The committee is chaired by Colin Greaves, Lay Member for Governance. The membership of the committee can be found on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

Across the year, the committee reviewed a number of internal audit reports including action plans, relating to the following service areas:

- Risk Management report
- General Data Protection Regulations report
- Conflicts of Interest report
- Medicines Management report
- Continuing Healthcare/Funded Nursing Care follow-up report.

These reports were submitted to the committee in May 2018 by the CCG's out-going internal auditors PwC.

The following reports were issued by BDO (the CCG's current internal auditors) during the financial year 2018/19:

- Human Resources – Starters and Leavers report
- Conflicts of Interest report
- Assessment of Risk Maturity (advisory) report
- Data Security and Protection Toolkit report
- Adult Safeguarding report
- Primary Care Commissioning Committee report
- Key Financial Systems report
- General Data Protection Regulations Implementation report
- Continuing Healthcare (Adults) report
- STP Solutions report.

In addition, the committee has oversight and receives regular reports on the following areas:

- Counter Fraud
- Declarations of Interest including the gifts and hospitality registers
- ICS Savings/Solutions report
- Risk Management (CRR and GBAF)
- Procurement Decisions
- Waivers of Standing Orders
- Aged Debtor report.

The Quality & Governance Committee

The Quality & Governance Committee is chaired by Julie Clatworthy, Registered Nurse and is responsible for the assurance of quality and patient safety issues. The committee is responsible for reviewing and scrutinising clinical risks, as well as governance matters covering policies and human resources. The membership of the committee can be found on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

During 2018/19, the committee met six times and was quorate on each occasion. The committee had oversight of the following:

- Quality issues across Gloucestershire providers through the Quality Report and dashboards
- Policies including approval of the effective clinical commissioning, (including the Assisted Conception Policy), HR and governance policies
- LeDeR Mortality Review
- Safeguarding policies and reports including safeguarding priories, the Annual Health Report for Children in Care and Adverse Childhood Experiences presentation. In addition to Working Together 2018' update on the changes to legislation and local arrangements.
- Data Security and Information Governance updates
- CCG Workforce reports, and Staff Survey 2018 report
- GCCG and Gloucestershire provider trusts staff survey findings
- Health and Safety briefings.

Primary Care Commissioning Committee (PCCC)

As the CCG has delegated authority for the commissioning of primary care, it has an established sub-committee which manages the delivery of primary care services, within the context of the overall CCG Plan. The committee is chaired by Alan Elkin, Lay Member for Patient and Public Involvement.

The membership of the committee can be found on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

This year, the committee met nine times during the year; three of those meetings were Extraordinary PCCC meetings that required urgent decisions. Meetings were quorate on each occasion. The committee approved the following:

- Application for a change of the practice boundary from Leckhampton Surgery
- Merger Application from St Peter's Road and The Avenue Surgery
- Application to merge from Phoenix Surgery and Romney House Surgery
- Application from St Catherine's Surgery to close their branch surgery at the Healthy Living Centre, Cheltenham
- Application by Springbank Surgery for the provision of general medical services from Hesters Way Healthy Living Centre (HLC)
- Cheltenham, Prestbury Road, Premises Development proposal
- Church Street Practice as the preferred provider of Marybrook Medical Centre primary care services.

Primary Care Commissioning Committee meeting papers are available on the CCG's website here: **www.gloucestershireccg.nhs.uk/category/board-meetings/**.

Priorities Committee

The purpose of the priorities committee is to advise the local NHS health economy as to the health care interventions and policies that should be given high or low priority. The Priorities Committee helps the CCG and its localities choose how to allocate its resources to promote the health of the local community, based on the local health needs assessment. The committee is chaired by Dr Andy Seymour, Clinical Chair. Committee membership is detailed on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

During 2018/19, the committee met on 6 occasions and was quorate at each meeting. The committee approved business cases for the following schemes:

- Community Stroke Rehabilitation Unit
- Cyber Security
- Cardiovascular Disease Prevention
- Postural Management scheme
- Children Young People (CYP) Weight Management scheme
- Eating Disorders project
- Emotional Support for Survivors of Domestic Abuse
- ENT Ear Irrigation service
- KiActiv
- Children's Learning Disabilities Waiting List
- Additional Prescribing Advisors.

A number of other schemes were also considered at the March 2019 committee meeting with decisions pending on which schemes will be funded for 2019/20.

Remuneration Committee

The Remuneration Committee determines and approves the remuneration, fees and other allowances for CCG employees (specifically, very senior managers, consultants and contractors etc).

The membership of the committee can be found on the CCG's website: **www.gloucestershireccg.nhs.uk/about-us/the-governing-body/**.

The Remuneration Committee is chaired by Alan Elkin, Lay Member for Public and Patient Engagement. It formally met on four occasions during 2018/19.

The full remuneration report can be found within the CCG Annual Report and Accounts.

Annual assessment of committee effectiveness

Each of the Governing Body sub-committees conducts an annual assessment of the committee's effectiveness. A survey is completed by committee members and a report along with recommendations for improvement is produced for each of the committees.

Committee chairs are scheduled to meet in May 2019 to discuss how the committees are working and any changes or improvements to be made during 2019/20. A review will be undertaken to ascertain any gaps or duplication of functions and business activities with a view to making systematic changes and improvements.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance.

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

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

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

Discharge of Statutory Functions

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

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

Risk management arrangements and effectiveness

The CCG has maintained a clear view of the keys risks affecting its strategic, corporate and directorate activities through the implementation of a three lines of defence model; the Governing Body's Assurance Framework (GBAF) containing key strategic risks reported to the Governing Body, the Corporate Risk Register (CRR), containing high level operational risks and Directorate Risk Registers with detailed directorate risks.

The GBAF along with the CRR is reported to the Audit and Risk Committee. The Quality and Governance Committee has oversight of clinical risks and receives the CRR at each of its meeting for review. The Core Leadership team reviews both the GBAF and CRR on a bi-monthly basis. All directorate risk registers are held and managed at a local level.

This systematic approach is detailed in the Risk Management Policy. This approach tracks:

- Risk identification, their cause and effect
- How risks are being managed
- The likelihood of occurrence and impact
- Risk rating – escalation and de-escalation process
- Their potential impact on the successful achievement of the CCG's objectives.

The GBAF identifies the key risks (those rated 12 and above) actions, controls and assurances that have been put in place by the organisation and that may have an impact on the CCG's principal and strategic objectives.

The CRR identifies those high-level operational risks that could threaten the achievement of the CCG's operational objectives. The CCG has utilised the National Patient Safety Agency (2006) Risk Assessment Tool and the (5x5) Risk Matrix to grade and frame risk scores, and to demonstrate what type of risk the CCG looks to identify in the areas of safety, quality, finance, statutory compliance, people, claims and complaints.

Key risks are owned by an Executive Director to ensure appropriate accountability for the management of risk. The Governance team provides oversight, challenge and consistency checks of risks on the directorate risk registers that populate the CRR and GBAF.

Throughout 2018/19, the Governing Body regularly received reports on risk through its respective committees. The Audit and Risk Committee scrutinise and challenge the risks on the CRR and GBAF providing effective feedback to directors; the committee acts as the 'Assurance Committee' monitoring the quality of the GBAF and the CRR and refers significant issues to the Governing Body.

The committee supports the Governing Body by ensuring that effective internal control arrangements are in place. The Audit and Risk Committee receives and considers the latest iteration of the GBAF and CRR at every meeting along with updates on significant developments. The Quality and Governance Committee focuses on clinical risks, ensuring that there is alignment between the risks highlighted in the quality and safety reports reported to the committee and the CRR. This committee escalates quality risks, where appropriate to Audit and Risk Committee.

The Audit Committee provides assurance of the robustness of the risk management framework, structure and processes. The Governing Body has played a key role in reviewing the risk management system. The Executive Team has been pivotal in the escalation and de-escalation of risk and assessing the quality of directorate risks that are transferred onto the CRR and GBAF.

Capacity to Handle Risk

In 2018/19, BDO the CCG's internal auditors conducted an assessment of the CCG's risk maturity. The objective of the risk maturity assessment was to ensure that an effective risk management culture becomes embedded across the CCG by highlighting areas where processes and practices could be improved. The purpose of this work was primarily advisory and did not generate an assurance opinion.

The report highlighted areas of good practice including that the CCG has clear themed strategic objectives in place; leadership for risk management is clearly provided by the Governing Body with delegated responsibility to the Audit and Risk Committee and that a training programme is in place for staff in risk management.

Following the Internal Audit review, the CCG:

- Commissioned new risk management software which will be implemented in May 2019 along with training for staff including risk leads
- The Audit and Risk Committee drafted a risk appetite statement to be included in the Risk Management Policy.

Key risks identified in 2018/19

There were a number of key risks reported during the 2018/19. High level risks rated at 12 or more are reported through the Governing Body Assurance Framework. A number of key risks were the focus of dedicated Governing Body business sessions, held on a monthly basis.

Between 1 April 2018 and 31 March 2019, 11 risks were added to the Corporate Risk Register. 12 have been closed within the year. 32 risks remain open which were added prior to 31 March 2019.

Of the remaining 32 open risks, 7 of the risks had been originally rated as high risks (16) by 31 March 2019 only one of those risks was still rated as a high risk (16) see below:

- South Western Ambulance Service NHS Foundation Trust (SWAST) had identified a risk in the South West due to call stacking. In Gloucestershire the risk is in category 2 patients where waits are longer than target times though Category 1 patients are responded to within the required times. Work has been undertaken to tackle this risk including escalation plans in place, system wide working between CCGs on improvement plans and more resources invested in additional ambulances and crews.

Other key high rated risks include:

- Risk to Non-Emergency Patient Transport KPI delivery and patient experience and procurement risks for the new contract scheduled to commence in June 2019. This risk has been reduced to 12 (Amber) due to the actions undertaken to produce a revised and updated service specification, and undertake a procurement process. The procurement process has been completed and mobilisation arrangements for the new provider are underway.
- Implementation of the Electronic Patient Record system within Gloucestershire Hospitals NHS Foundation Trust (GHFT). There was also a risk that there was no reportable data for maternity services. This had been originally rated as a high risk (16) but has been downgraded to an amber rated risk (12) due to the improvement actions undertaken. This includes a comprehensive recovery programme; the Trust has put in place strengthened project infrastructure which includes support from the CCG; with a deeper dive into the identification of coding changes.

The outstanding risks in place on 31 March 2019 are carried over into the new financial year and will continue to be managed within the Risk Management Framework described within this statement.

The risk profile of the CCG is subject to on-going in-year revision. At the end of the 2019/20 financial year, there were 32 risks on the Corporate Risk Register.

As Accountable Officer I can confirm that there have been no significant lapses of protective security.

Other sources of assurance

Internal Control Framework

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

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

Annual audit of conflicts of interest (CoI) management

The revised statutory guidance on managing conflicts of interest for CCGs (published 16 June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHS England has published a template audit framework.

A detailed review of conflicts of interest audit was undertaken in 2018/19 and assurance of 'substantial assurance' for design and moderate for operational effectiveness was achieved. Overall the internal audit review was positive. The report noted that significant work had been undertaken to improve the CCG's systems and processes for conflicts of interests and this was recognised in the internal audit report, which identified a number of areas of good practice. These included annual and regular reviews of registers of interests, gifts and hospitality and procurement decisions that were published on the CCG's website; a clear process for reporting and managing breaches, a Conflicts of Interests Guardian identified and training in place for staff on conflicts of interests.

Areas identified for improvement related primarily to ensuring processes were embedded across all teams and further training for staff to embed the processes is now in train.

Data Quality

Governing Body members consider data quality to be an integral part of its system of internal controls in order that it can assess both the effectiveness and performance of the organisation and its contracted services.

During the course of 2017/18, there have been issues identified with data quality due to problems associated with the implementation of the Patient Administration System at GHFT. However, considerable work has been progressed within the Trust, improvements have been made to the system during 2018/19 and the quality of data has improved.

Information Governance & Data Security

The NHS Data Security Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information; this is supported by the Data Security and Protection Toolkit and the annual submission process by the CCG provides assurances to the Clinical Commissioning Group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

As part of the annual Data Security and Protection Toolkit submission a comprehensive assessment of information security was undertaken; further assurance has been provided by the CCG's internal auditors who reviewed the submission. The effectiveness of these measures is reported to, and monitored by, the Data Security Working Group reporting to the Quality and Governance Committee. This includes details of any personal data related serious incidents, the CCG's annual data security toolkit assessment and reports of other IG incidents and audit reviews.

In 2018/19, the CCG made a toolkit submission that met the Data Security and Protection standards.

There were no serious incidents that have been reported by the Clinical Commissioning Group relating to data security breaches.

In compliance with NHS Digital Information Governance Toolkit, the CCG ensures that all key information security risks are monitored and controlled, this is via its informatics providers: South, Central and West Commissioning Support Unit (CSU) and Countywide IT Services who ensure that 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. The CCG has a robust process for recording and managing incidents which are monitored by the CSU's governance team with input from Information Governance and Information Security experts as required.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information.

We have established an information governance management framework and have developed information governance processes and procedures in line with the information governance toolkit.

We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities. At the end of March 2019 approximately 96% of CCG staff had completed IG mandatory training.

During 2018-19, work was undertaken to review the CCG's information governance framework, policies and procedures. These policies and procedures were updated and approved by the Quality and Governance Committee in October and December 2018. Work was also undertaken to improve the Data Privacy Impact Assessments (DPIAs), information flows, and information management asset registers. During 2018/19 a schedule of General Data Protection Regulations (GDPR) training was undertaken, in addition to face to face and e-learning information governance training.

Business Critical Models

In line with best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, I confirm that an appropriate framework and environment is in place to provide quality assurance of business critical models.

Third party assurances

The CCG is working in partnership with Gloucestershire County Council to manage both the Better Care Fund and other partnership budgets. The operation of the Better Care Fund is considered as part of the performance monitoring report received at every formal meeting of the Governing Body. The arrangement is governed by a Section 75 agreement signed off by both organisations.

Control Issues

The CCG can state that it has no critical issues of control to report.

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

The Governing Body has overarching responsibility for ensuring the CCG carries out its activities effectively, efficiently and economically. To ensure this:

- There are procurement processes to which the CCG adheres. There is a scheme of delegation which ensures that financial controls are in place across the organisation. The roles of the accountable and delegated committees and groups are shown within this report
- The Governing Body receives a report from the Chief Finance Officer at each of its Public Governing Body meetings in addition to finance and performance reporting at the Business Sessions on a monthly basis
- The Audit and Risk Committee receives regular reports on financial governance, monitors the Internal Audit programme and reviews the draft and final annual accounts

- The CCG has a programme of Internal Audits that provides assurance to the Governing Body and Executive Team of the effectiveness of its internal processes
- The CCG's annual accounts are reviewed by the Audit and Risk Committee and audited by our external auditors.

Following completion of the planned audit work our external auditors will issue an Independent and objective opinion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources.

CCG Improvement and Assessment – Quarter 4 (April 2019)

Quarter 4 NHS England Assurance meeting took place in April 2019; the CCG retained its Q3 assessment rating Good/Green with Green Star for Governance.

Delegation of functions

The CCG has a defined scheme of reservation and delegation in the CCG's Constitution approved by its GP members, the Council of Members.

This identifies which functions are reserved for the Council of Members and Governing Body and which are delegated for discharge across the CCG in line with effective use of resources and risk management processes. In support of this the CCG has a Detailed Scheme of Delegation which identifies what financial responsibilities the following levels of authority have:

- Level 1 – CCG Governing Body
- Level 2 – Accountable Officer
- Level 3 – Chief Finance Officer
- Level 4 – Other Directors
- Level 5 – Budget holders, in accordance with specific levels of authority granted to individuals
- Level 6 – all other office holders.

The Governing Body receives regular reports from all its committees to provide assurance regarding the arrangements for the discharge of delegated functions, including those relating to quality, finance, risk and performance, particularly relating to constitution targets.

The Governing Body receives minutes from the Primary Care Commissioning Committee ensuring they are meeting their delegated duties and that conflicts of interests are being effectively managed. Internal Audit provides independent assurance on the processes in place as part of the annual internal audit plan which is supplemented by the oversight of the assurance of the CCG's value for money, economy, efficiency and effectiveness by the External Auditors.

Counter fraud arrangements

The Chief Finance Officer is the lead for counter fraud within the CCG and works with the nominated Local Counter Fraud Specialist to develop the annual work plan which is approved by the Audit and Risk Committee.

The CCG's Counter Fraud Service is provided by the Gloucestershire Shared Service for NHS (GSS) which has a Memorandum of Support with Audit South West a provider of internal audit, counter fraud and consultancy services to healthcare organisations within the South West. GSS employs a team of three accredited Local Counter Fraud Specialists who provide the full range of Counter Fraud functions.

The Head of Counter Fraud meets regularly with the Chief Finance Officer to discuss progress against the Action Plan and areas of potential risk. During 2018/19 regular reports and updates were given to the Audit and Risk Committee on:

- Counter fraud Annual Report
- Counter fraud work-plan
- Counter fraud Alerts

- National counter fraud initiative
- CCG counter fraud survey results
- Current cases and proactive counter fraud work
- Counter fraud training – face to face and development of an e-learning package.

Counter Fraud deliver face to face training to all staff as a part of the CCG's Statutory and Mandatory Training. The Governing Body also receives annual Counter Fraud training. Fraud awareness is raised through updates in the CCG's Team Brief meeting and e-bulletin and staff meeting notices.

The Head of Counter Fraud attends all Audit and Risk Committee meetings to provide both a written and verbal update on progress against the Action Plan and the Standards for Commissioners.

Head of Internal Audit Opinion

The role of internal audit is to provide an opinion to the Governing Body, through the Audit and Risk Committee, on the adequacy and effectiveness of the internal control system to ensure the achievement of the organisation's objectives in the areas reviewed.

The annual report from internal audit provides an overall opinion on the adequacy and effectiveness of the organisation's risk management, control and governance processes, within the scope of work undertaken by our firm as outsourced providers of the internal audit service. It also summarises the activities of internal audit for the period. The basis for forming my opinion is as follows:

- An assessment of the design and operation of the underpinning Governing Body and Assurance Framework and supporting processes
- An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses
- Any reliance that is being placed upon third party assurances

Overall, we are able to provide moderate assurance that there is a sound system of internal control designed to meet the CCG's objectives and that controls are being applied consistently. Moderate 4 assurance is our second highest assurance rating and, under the previous NHS internal audit standards, is equivalent to the following: significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.

In forming our view we have taken into account that:

- The CCG is forecast to deliver its planned breakeven position in year. Its cumulative surplus that it has built up will total £21,465k.
- The CCG has displayed strong controls in relation the key financial system, conflicts of interest, GDPR implementation and primary care commissioning processes.
- Improvements required to Human Resources, Adult Safeguarding and Continuing Healthcare processes have contributed to the overall 'moderate' opinion.
- Good progress has been made during the year with the implementation of the actions arising from the audit work.

Report Issued	Recommendations & Significance			Overall Report Conclusions	
	H	M	L	Design	Operational Effectiveness
Key Financial Systems	0	0	1	Substantial	Substantial
Primary Care Commissioning	0	0	2	Substantial	Substantial
Data Security & Protection Toolkit – advisory report				n/a	n/a
Risk Maturity Assessment	0	18	0	n/a	n/a
Human Resources – Starters & Leavers	0	2	1	Moderate	Moderate
Adult Safeguarding	0	8	1	Moderate	Moderate
GDPR Implementation	0	0	2	Substantial	Moderate
Conflicts of Interest	0	1	6	Substantial	Moderate
Continuing Healthcare	0	3	2	Moderate	Moderate

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

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within NHS Gloucestershire Clinical Commissioning Group who have responsibility for the development and maintenance of the internal control framework.

I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

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

I have been advised on the implications of the result of this review by:

- the Governing Body
- the Audit and Risk Committee
- The Quality and Governance Committee; and
- Internal Audit.

The conclusions of each were that there were no significant control issues.

Conclusion

No significant internal control issues have been identified during 2018/19.

Mary Hutton

Accountable Officer

May 23 2019

7 REMUNERATION AND STAFF REPORT

Remuneration and staff report

Remuneration and Staff Report

The Remuneration Committee makes recommendations to the Governing Body about the remuneration, fees and allowances for senior managers and the persons in senior positions within the CCG, including those who regularly attend the Governing Body meeting, who are appointed by or who provide services to the CCG.

Details on the Remuneration Committee are shown within the Governance report including membership and number of meetings. Full details of the remuneration paid to the Governing Body members and senior employees are provided within the Remuneration Report included herein, together with their pension entitlements.

Senior Managers Remuneration Report

For the purpose of this report, senior managers are defined as being 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Clinical Commissioning Group'. This means those who influence the decisions of the organisation as a whole rather than the decisions of individual directorates or departments. Such persons will include Lay Members. It is the Remuneration Committee that recommends the reward packages of Executive Directors to the Governing Body. Information on the Remuneration Committee can be found in the Governance Statement.

Remuneration Policy

The policy on remuneration of senior managers has been set using national CCG remuneration guidance and principles within "Clinical Commissioning Groups: Remuneration guidance for Chief Officers (where the senior manager also undertakes the Accountable Officer role) and Chief Finance Officers". The CCG does not have a policy for performance related pay for its senior managers.

Senior Manager Contracts

Senior officer appointments to the CCG are consistent with the employment policies of the CCG.

Where appropriate, duration of contracts is determined by the needs of the business. Notice periods take account of statutory requirements and terms previously established by the NHS very senior managers' pay framework.

Liability in the event of early termination is in accordance with the NHS Agenda for Change terms and conditions handbook. Further guidance is also provided by NHS England on the termination and reengagement of senior managers. They also include any additional pension benefit accrued to the members as a result of their purchasing additional years of pension service in the scheme at their own cost. Cash Equivalent Transfer Values (CETVs) are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Staff Report

NHS Gloucestershire CCG is one of the largest CCGs in England, employing a headcount staff of 364 as at the 31 March 2019.

The CCG has a well-structured HR service with the Commissioning Support Unit's ConsultHR service providing transactional and employee relations HR services. The CCG has internal HR resources with the Associate Director of Corporate Affairs responsible for HR strategy and organisational development working closely with ConsultHR.

The CCG has set up a HR/OD Steering Group that meets on a quarterly basis and includes representation from the six directorates, members of the Governing Body and HR professionals. The group is chaired by the Lay Member for Patient and Public Involvement, Jo Davies. The group is responsible for oversight and delivery of the HR/OD strategy and plan which is aligned to the ICS HR/OD strategy.

The group has had oversight of number of key projects and plans including the HR/OD action plan, annual staff survey, HR policies, staff event programme, staff appraisals and learning and development activities.

The group also supports the work undertaken by the Disability Confident Employer Group.

The Joint Staff Consultative Committee (JSCC)

The JSCC has an important role providing staff feedback and input to the development of HR plans, policies, staff events and staff survey, amongst many other things. The committee meets on a monthly basis and is chaired by the Executive Nursing Director and Quality Lead. There is good representation from staff working across the CCG, as well as HR professionals in attendance.

Staff engagement

As part of the CCG's HR/OD strategy, work has been undertaken to strengthen its staff engagement activities including:

- Active engagement of JSCC and staff in shaping the staff survey; production of the report findings, presentations at staff forums and the development of an action plan
- Focus groups have been arranged with staff to obtain more feedback about their experiences at work and what improvements can be made during 2019
- Staffing events based on the feedback staff have given via the staff survey and suggestion email box
- Monthly face to face Team Briefing sessions (led by the Accountable Officer and Clinical Chair), which is supported by a written Team Brief e-bulletin which is then distributed and discussed within individual teams
- Monthly Staff Awards. The presentation is held at the above session
- Monthly face to face Team Directorate team meetings
- Lunch and learn sessions run by staff to share their work and learning with other staff members e.g. the Fitbit Challenge – health and hustle, diabetes workshops, conflicts of interests etc
- Coffee connect which has been established and is working well, bringing together staff members from across the CCG over a coffee
- Development of 'CCG Live,' a website that holds information on all team briefs, policies, procedures and other information
- A-Z on the Staff Area of CCG Live containing new pages on corporate induction, policies and the staff survey 2018
- New web pages that have been developed by staff focusing on learning and development; disability confident employer, health and mental health well-being
- The CCG Executive Team meets with senior managers on a monthly basis
- 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. The staff survey findings 2018 confirmed that over 83% of respondents reported that they had regular 1:1 with their manager that were effective and over 71.61% confirmed that their most recent appraisal was effective and made them feel motivated about my development and work programme for the next 12 months.

Staff survey results

The staff engagement activities undertaken by the CCG have been positively received by staff and are exemplified in the staff survey results as shown by some of the top scoring results for 2018 survey:

- The CCG provides equal opportunities to staff 93.98% (2018) 67.3% (2017
- My line manager supports the CCG's commitment to flexible working 92.47% (2018) 68% (2017)

- I know who to ask questions about data security 91.04% (New)
- I know and understand the CCG's vision & values 88.98% (2018) 75% (2017)
- There is a positive culture towards supporting carers 88.06% (new question)
- Lunchtime breaks/facilities for staff are suitable 87.10% (2018) no direct match closest food and catering question in 2017 scored 38%
- I value the purchase of additional leave 86.83% (new question)
- The CCG has a supportive culture towards the mental health of staff 86.27% (new question)
- I am able to make suggestions to improve work of team/dept 81.12% (2018) 64% (2017).

Staffing policies

The CCG like other NHS employers has a host of HR policies, user guides, forms and resources. Policies are formally reviewed both by the Executive Management Team and the JSCC, before being ratified and adopted by the Quality and Governance Committee prior to publication.

CCG Pay Policy

The CCG's pay policy mirrors Agenda for Change (AFC), staff receive pay awards in line with nationally negotiated AfC pay. Staff other than VSM do not receive performance related pay or bonuses.

The full range of HR policies currently in use can be found on the CCG's website here: **www.gloucestershireccg.nhs.uk/about-us/nhs-publication-scheme/our-policies-and-procedures/.**

Sickness absence data

Details of the level of sickness absence are given below. 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 ConsultHR, Occupational Health and Care First (Employee Assistance Programme).

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

Sickness data

NHS Gloucestershire CCG	18/19	17/18
Total days lost	1881	1,444
Total staff	282	257
Average working days lost	6.7	5.6

Ill health retirement

There were no early retirements on ill health grounds in 2018/19 (Nil in 2017/18).

Ill-health retirement	Nil	Nil

Disabled employees

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

The CCG's aim is to operate in ways which do not discriminate our potential or current employees with any of 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. The CCG publishes their employee profile by each of the nine protected characteristics, this helps the organisation to identify and address areas of under representation in a systematic manner as and when opportunities arise.

A Disability Confident Employer (DCE) Group has been established within the CCG with representatives from HR, JSCC and staff from across the 6 directorates. The CCG and Gloucestershire County Council jointly fund a Disability Employment Commissioner with expertise in disability and employment who advises the DCE Group.

The CCG's aim is to increase the participation of disabled employees within the CCG's workforce.

On 29 October 2018, the CCG was awarded the Disability Confident Employer status in light of the work undertaken to:

- successfully complete the Disability Confident self-assessment
- take all of the core actions to be a Disability Confident employer
- offer at least one activity to get the right people for our business and at least one activity to keep and develop our people.

The Executive Team and Quality and Governance Committee receive regular reports on the profile of the workforce including staff with disabilities (where known) in the bi-monthly and six monthly HR reports.

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

The Trade Union (Facility Time Publication Requirements) – Regulations 2017

The CCG confirms that there are no relevant union officials who are staff members of the CCG. No employee of the CCG takes time off during their working hours for the purpose of taking part in any activities in relation to which they are acting as a representative of a union.

Equalities monitoring

The CCG monitors equalities information and reports are given to the HR/OD group, Executive Team and the Quality and Governance Committee on the diversity of its workforce.

Gender	Headcount	%	FTE
Female	291	73.9	219.05
Male	103	26.1	78.83
Total	394	100.0	297.87

Ethnicity

Ethnic Group	Headcount	%	FTE
A White - British	329	83.50	253.62
B White - Irish	1	0.25	1.00
C White - Any other White background	5	1.27	3.75
CP White Polish	1	0.25	0.60
F Mixed - White & Asian	2	0.51	1.44
G Mixed - Any other mixed background	1	0.25	0.80
GE Mixed - Asian & Chinese	1	0.25	0.90
H Asian or Asian British - Indian	9	2.28	6.85
J Asian or Asian British - Pakistani	1	0.25	0.40
L Asian or Asian British - Any other Asian background	2	0.51	1.60
LH Asian British	1	0.25	0.40
M Black or Black British - Caribbean	2	0.51	1.48
N Black or Black British - African	3	0.76	2.80
R Chinese	1	0.25	0.80
S Any Other Ethnic Group	1	0.25	1.00
Unspecified	9	2.28	2.82
Z Not Stated	25	6.35	17.61
Grand Total	**394**	**100.0**	**297.87**

Age

Age Band	Headcount	%	FTE
<=20 Years	4	1.02	4.00
21-25	17	4.31	14.95
26-30	18	4.57	15.41
31-35	36	9.14	28.54
36-40	56	14.21	43.98
41-45	51	12.94	39.03
46-50	61	15.48	44.85
51-55	68	17.26	56.84
56-60	47	11.93	31.15
61-65	28	7.11	17.95
66-70	4	1.02	0.75
>=71 Years	4	1.02	0.42
Grand Total	**394**	**100.00**	**297.87**

Other employee matters

Equality and Diversity

We have a range of policies to promote equality and inclusion in the workplace. We will also be using the staff focus group to explore issues around equality and diversity; as well as staff ideas on how to improve diversity representation in the workforce and career opportunities for those with protected characteristics. This will link with our work around tackling the gender pay gap.

During 2018, the CCG participated in the national Insights Programme that encourages people from diverse backgrounds to gain experience as a non-executive director/lay member of NHS Boards and Governing Bodies. We hosted a placement for 6 months and are looking to do so again in 2019.

Health and Safety at work

The overall responsibility for CCG health and safety resides with the Executive Nurse Director, Quality Lead. The CCG has a contract with Commissioning Support Unit to provide specialist advice and training in health and safety at work. In addition the Business Manager for the Executive has a health and safety role within the workplace, undertaking monthly walkabouts through the building and checking and reporting on health and safety concerns. A quarterly Health and Safety report is produced and considered by the Quality and Governance Committee.

Fair Pay (subject to audit)

The annualised range of remuneration is £14k to £177.7k (£13.8k to £175.6k 2017/18).

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

The banded remuneration of the highest paid member of the governing body in the CCG in the financial year was £175k-£180k (£175k-£180k in 2017/18) on an annualised basis. This was 4.25 (4.39 in 2017/18) times the median remuneration of the workforce which was £41,724 (£40,428 in 2017/18). This is not a significant movement from the previous financial year. This figure is different to the remuneration table due to it being calculated on an annualised basis for part-time work.

In 2018/19, no employee received remuneration in excess of the highest paid member of the governing body. Total remuneration includes salary, non-consolidated performance-related pay, benefits in kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Off Payroll Engagements

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

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

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

	Number
Number of new engagements or those that reached six months in duration between 1 April 2017 and 31 March 2019 greater than £245 per day and that last for longer than six months:	1
Of which:	
No. Assessed as caught by IR35	1
No. assessed as not caught by IR35	0
Of which:	
No. engaged directly (via PSC contracted to department and are on the departmental payroll	1
No. of engagements reassessed for consistency/assurance purposes during the year	0
No. of engagements that saw a change to IR35 status following the consistency review	0

Off-payroll engagements of Board/Governing Body members and/or senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019:

	Number
Number of off payroll engagements of Board/Governing Body members and/or senior officials with significant responsibility during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This includes both on-payroll and off-payroll engagements.	21

Remuneration Report for NHS Gloucestershire CCG 2018-19 (subject to audit)

	2018/19						
Name & Title	Salary (bands of £5,000)	Expense Payments (taxable) to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500) * •	Total (bands of £5,000)
Dr Andrew Seymour, Clinical Chair	120-125	0	0	0	120-125	17.5-20	140-145
Mary Hutton, Accountable Officer	145-150	0	0-5	0	150-155	0	150-155
Mark Walkingshaw, Deputy Accountable Officer/ Director Of Commissioning Implementation	125-130	0	0	0	125-130	30-32.5	155-160
Cath Leech, Chief Finance Officer	115-120	0	0	0	115-120	17.5-20	135-140
Ellen Rule, Director of Transformation and Service Redesign	115-120	0	0	0	115-120	0	115-120
Helen Goodey, Director of Primary Care and Locality Development	105-110	0	0	0	105-110	22.5-25	130-135
Kim Forey, Director of Integration	50-55	0	0	0	50-55	22.5-25	75-80
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	45-50	0	0	0	45-50	5-7.5	50-55
Dr Lawrence Fielder, Clinical Commissioning Lead (Forest of Dean)	45-50	0	0	0	45-50	0	45-50
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	45-50	0	0	0	45-50	5-7.5	50-55
Dr Hein Le Roux, Deputy Clinical Chair	45-50	0	0	0	45-50	117.5-120	165-170
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	45-50	0	0	0	45-50	7.5-10	55-60
Dr Sheena Yerburgh, Clinical Commissioning Lead (Stroud & Berkeley Vale)	45-50	0	0	0	45-50	0-2.5	45-50
Dr Will Miles, Clinical Commissioning Lead (Cheltenham)	45-50	0	0	0	45-50	130-132.5	175-180
Julie Clatworthy, Registered Nurse	20-25	0	0	0	20-25	0	20-25
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead	105-110	0	0	0	105-110	0	105-110
Dr Alan Gwynn, Clinical Commissioning Lead (South Cotswolds)	45-50	0	0	0		0	45-50
Alan Elkin, Lay Member, Patient And Public Engagement	15-20	0	0	0	15-20	0	15-20
Colin Greaves, Lay Member, Governance	20-25	0	0	0	20-25	0	20-25
Joanna Davies, Lay Member, Patient & Public Engagement	5-10	0	0	0	5-10	0	5-10
Peter Marriner, Lay Member, Business	5-10	0	0	0	5-10	0	5-10
Dr Lesley Jordan, Secondary Care Clinical Advisor[1]	30-35	0	0	0	30-35	0	30-35

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

• Due to changes in the NHS pension scheme and, in particular, where individuals may have changed schemes in previous years this distorts the calculations.

[1]Payment is made to Dr Jordan's host Trust (Royal United Hospitals NHS Foundation Trust)

Name & Title	2017-18						
	Salary & Fees (bands of £5,000)	Taxable Benefits (rounded to nearest £00)	Annual Performance Related Bonuses (bands of £5,000)	Long Term Performance Related Bonuses (bands of £5,000)	Sub-total (band of bands)	All Pension Related Benefits (bands of £2,500)* •	Total (bands of £5,000)
Dr Andrew Seymour, Clinical Chair	120-125	-	-	-	120-125	17.5-20	140-145
Mary Hutton, Accountable Officer	140-145	-	-	-	140-145	17.5-20	160-165
Mark Walkingshaw, Deputy Accountable Officer/ Director Of Commissioning Implementation	120-125	-	-	-	120-125	92.5-95	215-220
Cath Leech, Chief Finance Officer	115-120	-	-	-	115-120	80-82.5	195-200
Ellen Rule, Director of Transformation and Service Redesign	110-115	-	-	-	110-115	67.5-70	180-185
Helen Goodey, Director of Primary Care and Locality Development	110-115	-	-	-	110-115	52.5-55	160-165
Kim Forey, Director of Integration	50-55	-	-	-	50-55	75-77.5	125-130
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	45-50	-	-	-	45-50	10-12.5	55-60
Dr Lawrence Fielder, Clinical Commissioning Lead (Forest of Dean) From 1st June 2017	35-40	-	-	-	35-40	165-167.5	200-205
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	45-50	-	-	-	45-50	10-12.5	55-60
Dr Hein Le Roux, Deputy Clinical Chair	45-50	-	-	-	45-50	-	45-50
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	45-50	-	-	-	45-50	112.5-115	155-160
Dr Sheena Yerburgh, Clinical Commissioning Lead (Stroud & Berkeley Vale)	45-50	-	-	-	45-50	190-192.5	235-240
Julie Clatworthy, Registered Nurse	20-25	-	-	-	20-25	-	20-25
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead	100-105	-	-	-	100-105	-	100-105
Dr Alan Gwynn, Clinical Commissioning Lead (South Cotswolds)	45-50	-	-	-		-	45-50
Alan Elkin, Lay Member, Patient And Public Engagement	15-20	-	-	-	15-20	-	15-20
Colin Greaves, Lay Member, Governance	20-25	-	-	-	20-25	-	20-25
Joanna Davies, Lay Member, Patient & Public Engagement	5-10	-	-	-	5-10	-	5-10
Peter Marriner, Lay Member, Business	5-10	-	-	-	5-10	-	5-10
Dr Raju Reddy, Secondary Care Clinical Advisor, to 30th April 2017	Payment is made to Dr Reddy's host Trust (Birmingham Childrens NHS Foundation Trust)						
Dr Lesley Jordan, Secondary Care Clinical Advisor, from 3rd July 2017	Payment is made to Dr Jordan's host Trust (Royal United Hospitals NHS Foundation Trust)						

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

• Due to changes in the NHS pension scheme and, in particular, where individuals may have changed schemes in previous years this distorts the calculations.

Pensions Report 2018-19 (subject to audit)

Name & Title	2018/19							
	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018	Real increase in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2019	Employers contribution to stakeholder pension
Name & Title	£000	£000	£000	£000	£000	£000	£000	£000
Dr Andrew Seymour, Clinical Chair	0-2.5	2.5-5	15-20	45-50	275	46	348	18
Mary Hutton, Accountable Officer *	0-2.5	0-2.5	35-40	110-115	796	50	900	17
Mark Walkingshaw, Deputy Accountable Officer/Director Of Commissioning Implementation	0-2.5	0-2.5	40-45	105-110	658	104	800	18
Cath Leech, Chief Finance Officer	0-2.5	0	40-45	100-105	709	93	840	17
Helen Goodey, Director of Primary Care and Locality Development	0-2.5	0	25-30	50-55	387	59	473	16
Kim Forey, Director of Integration	0-2.5	0	15-20	0	205	17	242	15
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	0-2.5	0	10-15	30-35	226	30	269	7
Dr Sheena Yerburgh, Clinical Commissioning Lead (Stroud & Berkeley Vale)	0-2.5	0	5-10	20-25	164	16	191	7
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	0-2.5	0	15-20	35-40	271	33	319	7
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	0-2.5	0	15-20	30-35	162	30	204	7
Dr Lawrence Fielder, Clinical Commissioning Lead (Forest of Dean)	0	0	5-10	20-25	159	5	175	7
Dr Will Miles, Clinical Commissioning Lead (Cheltenham)	5-7.5	17.5-20	5-10	25-30	77	139	225	7
Dr Hein Le Roux, Deputy Clinical Chair	5-7.5	10-12.5	10-15	20-25	131	74	215	7
Ellen Rule, Director of Transformation and Service Redesign	Ellen Rule has opted out of the NHS Pension scheme							
Dr Lesley Jordan, Secondary Care Clinical Advisor	Dr Jordan is not an employee of NHS Gloucestershire CCG and payment is made to his host Trust (Royal United Hospitals NHS Foundation Trust)							
Dr Alan Gwynn, Clinical Commissioning Lead (South Cotswolds)	Dr Gwynn has opted out of the NHS pension scheme							
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead	Dr Andrews-Evans has opted out of the NHS pension scheme							
* The figures are part year due to opting out of the pension scheme from February 19								

Pensions Report 2017-18 (subject to audit)

Pensions Report for NHS Gloucestershire CCG 2017-18 Name & Title	Real increase in pension at pension age (Bands of £2,500)	Real increase in pension lump sum at pension age (Bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (Bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (Bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017 £000	Real increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Employer's contribution to stakeholder pension £000
Dr Andrew Seymour, Clinical Chair	0-2.5	2.5-5	10-15	40-45	234	39	275	18
Mary Hutton, Accountable Officer	0-2.5	5-7.5	35-40	105-110	715	74	796	21
Mark Walkingshaw, Deputy Accountable Officer/ Director Of Commissioning Implementation	5-7.5	7.5-10	40-45	100-105	543	110	658	18
Cath Leech, Chief Finance Officer	2.5-5	5-7.5	40-45	100-105	599	104	709	17
Ellen Rule, Director of Transformation and Service Redesign	2.5-5	2.5-5	20-25	45-50	241	42	286	11
Helen Goodey, Director of Primary Care and Locality Development	2.5-5	2.5-5	20-25	50-55	320	64	387	16
Kim Forey, Director of Integration	2.5-5	-	10-15	-	131	71	203	15
Dr Caroline Bennett, Clinical Commissioning Lead (North Cotswolds)	0-2.5	0-2.5	15-20	35-40	251	17	270	7
Dr Sheena Yerburgh, Clinical Commissioning Lead (Stroud & Berkeley Vale)	7.5-10	22.5-25	5-10	20-25	0	164	164	7
Dr Will Haynes, Clinical Commissioning Lead (Gloucester City)	0-2.5	0-2.5	15-20	35-40	251	18	271	7
Dr Jeremy Welch, Clinical Commissioning Lead (Tewkesbury, Newent & Staunton)	5-7.5	12.5-15	15-20	40-45	149	37	187	6
Dr Lawrence Fielder, Clinical Commissioning Lead (Forest of Dean) From 1st June 2017	5-7.5	17.5-20	5-10	20-25	0	132	159	5
Dr Raju Reddy, Secondary Care Clinical Advisor	Dr Reddy is not an employee of NHS Gloucestershire CCG and payment is made to his host trust (Birmingham Childrens NHS Foundation Trust)							
Dr Hein Le Roux, Deputy Clinical Chair	Dr Le Roux has opted out of the NHS pension scheme							
Dr Alan Gwynn, Clinical Commissioning Lead (South Cotswolds)	Dr Gwynn has opted out of the NHS pension scheme							
Dr Marion Andrews-Evans, Executive Nurse & Quality Lead	Dr Andrews-Evans has opted out of the NHS pension scheme							

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.

Average Contracted WTE of Staff Groupings by Occupational Code (excluding Directors, Non Executive Directors, Lay Members & Off Payroll engagements)	18/19			17/18		
	Male	Female	Total	Male	Female	Total
Senior Manager G0 (Band 8D and Above)	6	6	12	5	5	10
Manager G1 (Band 8A, 8B, 8C)	18	38	56	21	55	76
Clerical and Administrative G2 (Band 7 and Below)	39	102	141	38	127	165
Nursing, midwifery and health visiting staff	3	34	37			0
Scientific, therapeutic and technical staff	5	27	32			0
Local Snr Mgr Miscellaneous	0	0	0			0
Sub Totals	71	207	278	64	187	251
Grand Total		278			251	

Staff profile (subject to audit)

The profile of staff within the CCG, based on the average number of Whole Time Equivalent contracted in 2018-19, is as presented in the table below. This is referred to in note 4.2 of the Annual Accounts

Avg No WTE contracted (including Directors & Off Payroll engagements)	18/19			17/18		
	Director	Other Ee	Total	Director	Other Ee	Total
total Staff	7	284	291	7	256	263
of which:						
Perm	7	264	271	7	232	239
Other	0	20	20	0	24	24
of which:						
Male	1	73	74	1	65	66
Female	6	211	217	6	191	197

Staff costs including employers national insurance and pension (audited)

	18/19			17/18		
	Directors £'000	Other Ees £'000	Total £'000	Directors £'000	Other Ees £'000	Total £'000
total Staff Costs	1,017	13,957	14,974	1,007	12,764	13,771
of which						
permanent	1,017	13,168	14,185	1,007	11,831	12,838
other	-	789	789	-	933	933

Employee benefits and staff numbers (subject to audit)

	2018/19			2017/18		
	Total	Permanent Employees	Other	Total	Permanent Employees	Other
	£'000	£'000	£'000	£'000	£'000	£'000
Employee Benefits						
Salaries and Wages	12,223	11,434	789	11,272	10,339	933
Social Security Costs	1,212	1,212	0	1,105	1,105	0
Employer Contributions to NHS Pension scheme	1,536	1,536	0	1,393	1,393	0
Other Pension Costs	3	3	0	0	0	0
Apprenticeship Levy	50	50	0	43	43	0
Termination Benefits	91	91	0	0	0	0
Gross employee benefits expenditure	**15,115**	**14,326**	**789**	**13,813**	**12,880**	**933**
Total – Net admin employee benefits including capitalised costs	**15,115**	**14,326**	**789**	**13,813**	**12,880**	**933**
Less: Employee costs capitalised	0	0	0	0	0	0
Net employee benefits excluding capitalised costs	**15,115**	**14,326**	**789**	**13,813**	**12,880**	**933**

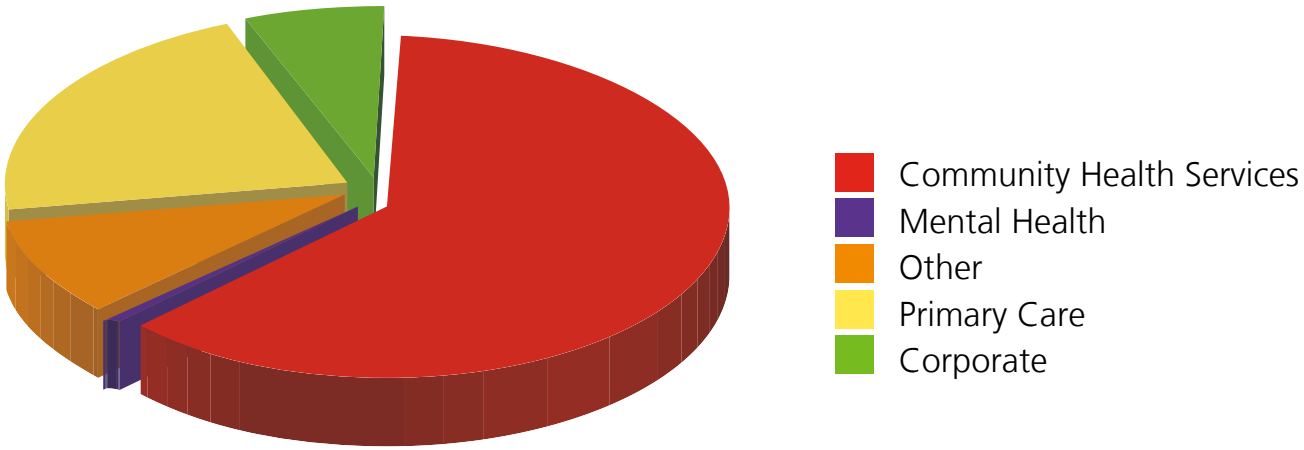
The largest increase in staff groups in 2018/19 related to increases in clinical staff within both the continuing healthcare and clinical pharmacy teams. This, also, included new pharmacist investment within general practice at locality level.

- There have been no significant awards made to past senior managers in 2018/19
- There has been no compensation on early retirement or for loss of office in 2018/19
- There have been no payments to past directors in 2018/19
- There have been 4 exit packages paid in 2018/19.

Exit Package cost band (including any special payment element)

- No staff on Very Senior Manager contracts earn in excess of £150,000 pa on a pro-rata basis.

Consultancy



Consultancy costs of £613k in 2018/19 were spent in the following areas.

External Audit

The CCG's external auditors are Grant Thornton UK LLP. The cost of the annual statutory audit of the 2018/19 Financial Statements was £62.9k. The cost was determined based upon the size of the CCGs commissioning budget. The CCG did not receive any additional audit services from Grant Thornton in year.

Mary Hutton,
Accountable Officer
May 23 2019

8 THE FINANCIAL STATEMENTS

Independent auditor's report to the members of the Governing Body of NHS Gloucestershire CCG

Report on the Audit of the Financial Statements

Opinion

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

In our opinion, the financial statements:

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

Basis for opinion

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

Conclusions relating to going concern

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

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

Other information

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

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we

identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

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

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

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

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

Opinion on regularity required by the Code of Audit Practice

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

Matters on which we are required to report by exception

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

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

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

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

As explained more fully in the Statement of Accountable Officer's responsibilities set out on pages 42 to 43, the Accountable Officer is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accountable Officer is responsible for assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

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

Matter on which we are required to report by exception - CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

We have nothing to report in respect of the above matter**.**

Responsibilities of the Accountable Officer

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us

to consider under the Code of Audit Practice in satisfying ourselves whether the CCG put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

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

Report on other legal and regulatory requirements – Certificate

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

Use of our report

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

Alex Walling, Key Audit Partner

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

Bristol

28 May 2019

ANNUAL ACCOUNTS

Completed in accordance with the DH Group Accounting Manual 2018/19 and NHS England SharePoint Finance Guidance Library

Mary Hutton

Accountable Officer

23 May 2019

Data entered below will be used throughout the workbook:

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

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

Please review and adjust to local reporting requirements

- Annual Accounts 2018-19

CONTENTS **Page Number**

The Primary Statements:

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

	Note	2018-19 £'000	2017-18 £'000
Income from sale of goods and services	3	(25,429)	(24,449)
Other operating income	3	(4,244)	(3,473)
Total operating income		**(29,673)**	**(27,922)**
Staff costs	4	15,114	13,814
Purchase of goods and services	5	882,359	850,808
Depreciation and impairment charges	5	113	99
Provision expense	5	1,095	1,890
Other Operating Expenditure	5	1,240	1,120
Total operating expenditure		**899,921**	**867,731**
Total Net Expenditure for the Financial Year		**870,248**	**839,809**
Other Comprehensive Expenditure		-	-
Comprehensive Expenditure for the year ended 31st March 2019		**870,248**	**839,809**

Statement of Financial Position as at 31 March 2019

	Note	2018-19 £'000	2017-18 £'000
Non-current assets:			
Property, plant and equipment	8	326	369
Total non-current assets		326	369
Current assets:			
Trade and other receivables	9	7,899	5,667
Cash and cash equivalents	10	9	6
Total current assets		**7,908**	**5,673**
Total assets		**8,234**	**6,042**
Current liabilities			
Trade and other payables	11	(50,642)	(47,188)
Provisions	12	(2,876)	(2,637)
Total current liabilities		**(53,518)**	**(49,825)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(45,284)**	**(43,783)**
Non-current liabilities		-	-
Assets less Liabilities		**(45,284)**	**(43,783)**
Financed by Taxpayers' Equity			
General fund		(45,284)	(43,783)
Total taxpayers' equity:		**(45,284)**	**(43,783)**

The notes on pages 7 to 26 form part of this statement

The financial statements on pages 3 to 6 were approved by the Governing Body on 23rd May 2019 and signed on its behalf by:

Chief Accountable Officer
Mary Hutton

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

	2018/19 General fund £'000	2017/18 General fund £'000
Balance at 1 April	(43,783)	(37,933)
Changes in NHS Clinical Commissioning Group taxpayers' equity		
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(870,248)	(839,809)
Net funding	868,747	833,959
Balance at 31 March	**(45,284)**	**(43,783)**

The notes on pages 7 to 26 form part of this statement

The General Fund is the only reserve for NHS Gloucestershire CCG.

Statement of Cash Flows for the year ended 31 March 2019

	Note	**2018-19 £'000**	2017-18 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(870,248)	(839,809)
Depreciation and amortisation	5	113	99
(Increase)/decrease in trade & other receivables	9	(2,232)	(1,379)
Increase/(decrease) in trade & other payables	11	3,453	6,384
Provisions utilised	12	(855)	(965)
Increase/(decrease) in provisions	12	1,095	1,890
Net Cash Inflow (Outflow) from Operating Activities		**(868,674)**	**(833,779)**
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment		(70)	(190)
Net Cash Inflow (Outflow) from Investing Activities		**(70)**	**(190)**
Net Cash Inflow (Outflow) before Financing		**(868,744)**	**(833,969)**
Cash Flows from Financing Activities			
Net Cash Inflow (Outflow) from Financing Activities		**868,747**	**833,959**
Net Increase (Decrease) in Cash & Cash Equivalents	10	**3**	**(11)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**6**	**17**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**9**	**6**

The notes on pages 7 to 26 form part of this statement

Notes to the financial statements

1 Accounting Policies

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

1.1 Going Concern

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

1.2 Accounting Convention

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

1.3 Pooled Budgets

NHS Gloucestershire CCG has entered into a pooled budget arrangement with Gloucestershire County Council [in accordance with section 75 of the NHS Act 2006]. Under the arrangement, funds are pooled for integrated community equipment services and note 15 provides details of the income and expenditure.

The pool is hosted by Gloucestershire County Council. NHS Gloucestershire CCG 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. This arrangement has not changed in 2018/19

1.4 Critical accounting judgements and key sources of estimation uncertainty

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

1.4.1 Critical accounting judgements in applying accounting policies

There are no critical accounting judgements in the application of accounting policies

1.4.2 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty. The CCG does not have any significant risk resulting in a material adjustment to the carrying amount.

- Partially Completed Spells

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

- Accruals for delegated co-commisioning of primary care services

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

- Accruals for Prescribing/Home Oxygen costs

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

• Provisions recognised as at 31st March 2019

The provision for continuing healthcare has been calculated by taking those claims outstanding at 31 March 2019 which had not previously been notified to NHS England. An assessment of the estimated/potential financial value is then made and a likelihood factor applied (based on previous experience). Other provisions have been calculated from estimates which have been influenced by the known factors affecting each issue as at the balance sheet date.

• Secondary Healthcare service costs

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

1.5 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application. This transition is not material

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The HM Treasury published Financial Reporting Manual (FReM) has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
The main source of revenue is NHS England and Gloucestershire County Council

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

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

Total net revenue expenditure for the year of £870m is funded by in year revenue resource allocations from NHS England. The revenue resource allocation is accounted for by crediting the general fund, but this funding is only drawn down from NHS England and accounted for, to meet payments as they fall due. The total funding credited to the general fund during the year was equal to the revenue resource allocation (see Statement of Changes to Taxpayers Equity on page 5).
The CCG's financial position is controlled by a limit on net expenditure rather than funding from DHSC. As such, the CCG's income from other activities is limited. The most significant element of income is where the CCG commissions service level agreements (for Mental Health and Community Services) through liaison with the local authority. In this instance, all figures are shown in gross terms (i.e. the contribution from the local authority is shown within Other Operating Revenue). The CCG does not enter into long term revenue contracts and, so, the assessment indicates that there is no impact of income recognition from adopting IFRS 15.
In 2017/18, revenue was accounted for under IAS18; Revenue whereby revenue in respect of services provided was recognised when, and, to the extent that, performance occurred, and was measured at the fair value of the consideration receivable. The transition to IFRS15 has had no material impact to the financial statements of the Clinical Commissioning Group.

1.6 Other Expenses

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

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

Notes to the financial statements

1.7 **Property, Plant & Equipment**

1.7.1 **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.

1.7.2 **Measurement**

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

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use.

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

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. Current values in existing use are determined as follows:

· Land and non-specialised buildings – market value for existing use; and,

· Specialised buildings – depreciated replacement cost.

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.

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

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.

1.7.3 **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.

Notes to the financial statements

1.7.4 **Depreciation, Amortisation & Impairments**

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

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

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

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

1.8 **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.

1.8.1 **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.

1.9 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the clinical commissioning group's cash management.

1.10 **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 has not been discounted due to the immaterial impact on the accounts given the short term nature of the CCG provisions

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.

1.11 **Clinical Negligence Costs**

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

Notes to the financial statements

1.12 **Financial Assets**

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

Financial assets are classified into the following categories:

- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

There has been a change in classification to financial assets at amortised cost at 1 April 2018 arising from the application of IFRS 9 (previously classified as loans and receivables in 2017/18 under IAS 39 Financial Instruments: Recognition and Measurement) but no change in valuation as the financial assets remain measured at amortised cost.

1.12.1 **Financial Assets at Amortised cost**

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

1.12.2 **Impairment**

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

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

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

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

1.12.3 **2017/18 Accounting policy for Financial Assets under IAS 39 Financial Instruments: Recognition and Measurement**

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 as loans and receivables.

1.13 **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.

After initial recognition, financial liabilities are measured at amortised cost using the effective interest method. The effective interest rate is the rate that effectively 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. There was no change in classification of financial liabilities at 1 April 2018 arising from the application of IFRS 9 (previously, IAS 39 Financial Instruments: Recognition and Measurement), financial liabilities remain measured at amortised cost.

Notes to the financial statements

1.14 **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 and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.15 **Value Added Tax**

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

1.16 **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).

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

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

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

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

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

The application of the Standards as revised would not have a material impact on the accounts for 2018-19, were they applied in that year.

2 Financial performance targets

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

	See below	**NHS Act 2006 Section**	**2018-19 Target**	**2018-19 Performance**	**Met (Y/N)?**	2017-18 Target	2017-18 Performance	Met (Y/N)?
Expenditure not to exceed income	2.1	223H (1)	899,926	899,921	Yes	872,249	867,731	Yes
Capital resource use does not exceed the amount specified in Directions	2.2	223I (2)	70	70	Yes	70	70	Yes
Revenue resource use does not exceed the amount specified in Directions	2.1	223I (3)	870,253	870,248	Yes	844,327	839,809	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	2.2	223J (1)	0	0	Yes	0	0	Yes
Revenue resource use on specified matter(s) does	2.3	223J (2)	0	0	Yes	0	0	Yes
Revenue administration resource use does not exceed the amount specified in Directions	2.4	223J (3)	13,713	13,712	Yes	13,602	13,539	Yes

2.1/2.2 Performance against Resource limit

	2018-19			2017-18		
	Revenue £000	**Capital £000**	**Total £000**	Revenue £000	Capital £000	Total £000
Notified Resource Limit	870,253	70	870,323	844,327	70	844,397
Total Other operating revenue	29,673		29,673	27,922		27,922
Total Income	**899,926**	**70**	**899,996**	**872,249**	**70**	**872,319**
Employee benefits	15,114		15,114	13,814		13,814
Operating costs	884,807	70	884,877	853,917	70	853,987
Total Expenditure	**899,921**	**70**	**899,991**	**867,731**	**70**	**867,801**
In year Surplus/(Deficit) spend	**5**	**0**	**5**	**4,518**	**0**	**4,518**
Cumulative surplus brought forward at 1 April	21,767		21,767	17,551		17,551
Cumulative surplus drawn down during the financial year	(302)		(302)	(302)		(302)
Cumulative surplus carried forward at 31 March	**21,470**	**0**	**21,470**	**21,767**	**0**	**21,767**

The overall notified resource limit above includes specific funding for Primary Care Delegated Co-Commissioning of £81.161m (2017/18: £79.980m).

3 Other Operating Revenue

	2018-19 Total £'000	2017-18 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**342**	306
Non-patient care services to other bodies	**25,087**	24,143
Other Contract income	**-**	-
Total Income from sale of goods and services	**25,429**	**24,449**
Other operating income		
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**461**	492
Non cash apprenticeship training grants revenue	**4**	1
Other non contract revenue	**3,779**	2,980
Total Other operating income	**4,244**	**3,473**
Total Operating Income	**29,673**	**27,922**

The increase in other non contract revenue relates to charges made to NHS England for national programmes in Cancer and Estates and Capital Projects including Estates and Technology Transformation Fund (ETTF) Projects

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

The majority of Income from sales of goods and services (Contracts) under IFRS15 above relate to contracts with Gloucestershire County Council, the timing of the income for contracts are over a period of time

There is no impact on either the Statement of Comprehensive Net Expenditure or the Statement of Financial Position relating to the effect of the application of IFRS15 on current year closing balances.

The accounting policy regarding revenue recognition has changed since 2017/18, IFRS 15 being adopted in full during 2018/19 (replacing IAS 18) and the new policy is disclosed under note 1.5

4. Employee benefits and staff numbers

4.1 Employee benefits

	2018-19			2017-18		
	Permanent Employees £'000	Other £'000	Total £'000	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits						
Salaries and wages	**11,434**	**789**	**12,223**	**10,340**	**933**	**11,273**
Social security costs	**1,212**	**0**	**1,212**	**1,105**	**0**	**1,105**
Employer Contributions to NHS Pension scheme	**1,535**	**0**	**1,535**	**1,393**	**0**	**1,393**
Other pension costs	**3**	**0**	**3**	**0**	**0**	**0**
Apprenticeship Levy	**50**	**0**	**50**	**43**	**0**	**43**
Termination benefits	**91**	**0**	**91**	**0**	**0**	**0**
Gross employee benefits expenditure	**14,325**	**789**	**15,114**	**12,881**	**933**	**13,814**
Less recoveries in respect of employee benefits (note 4.1.2)	**0**	**0**	**0**	**0**	**0**	**0**
Total - Net admin employee benefits including capitalised costs	**14,325**	**789**	**15,114**	**12,881**	**933**	**13,814**
Less: Employee costs capitalised	**0**	**0**	**0**	**0**	**0**	**0**
Net employee benefits excluding capitalised costs	**14,325**	**789**	**15,114**	**12,881**	**933**	**13,814**

4.2 Average number of people employed

	2018-19			2017-18		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**271**	**20**	**291**	**239**	**24**	**263**

4.3 Exit packages agreed in the financial year

	2018-19 Compulsory Redundancies		2017-18 Compulsory Redundancies	
	Number	£	Number	£
Less than £10,000	2	6,522	-	-
£25,001 to £50,000	1	30,092	-	-
£50,001 to £100,000	1	54,133	-	-
Total	**4**	**90,747**	**-**	**-**

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

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Agenda for Change terms and conditions of service.

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

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

4.4.1 Accounting valuation

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

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

4.4.2 Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

For 2018-19, employers' contributions of £1,721k were payable to the NHS Pensions Scheme (2017-18: £1,393k) were payable to the NHS Pension Scheme at the rate of 14.38% of pensionable pay. The scheme's actuary reviews employer contributions, usually every four years and now based on HMT Valuation Directions, following a full scheme valuation. These costs are included in the NHS pension line of note 11.

5. Operating expenses

	2018-19 Total £'000	2017-18 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	3,670	3,629
Services from foundation trusts	457,691	442,809
Services from other NHS trusts	107,115	105,525
Services from Other WGA bodies	5	-
Purchase of healthcare from non-NHS bodies	116,405	102,979
Purchase of social care	6,376	5,197
Prescribing costs	88,453	93,499
GPMS/APMS and PCTMS	89,333	86,057
Supplies and services – clinical	1,678	1,630
Supplies and services – general	1,354	1,393
Consultancy services	613	317
Establishment	6,211	3,861
Transport	74	72
Premises	1,704	1,689
Audit fees [1]	63	63
- Other audit related assurance services [2]	10	-
- Other non audit related services [3]	5	-
Other professional fees	646	1,028
Legal fees	103	145
Education, training and conferences	865	914
Total Purchase of goods and services	**882,374**	**850,808**
Depreciation and impairment charges		
Depreciation	113	99
Total Depreciation and impairment charges	**113**	**99**
Provision expense		
Provisions	1,095	1,890
Total Provision expense	**1,095**	**1,890**
Other Operating Expenditure		
Chair and Non Executive Members	724	620
Grants to Other bodies	414	433
Research and development (excluding staff costs)	36	60
Non cash apprenticeship training grants	4	1
Other expenditure	47	7
Total Other Operating Expenditure	**1,225**	**1,120**
Total operating expenditure	**884,807**	**853,917**

[1] In Accordance with SI 2008 no 489, The Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreements) Regulations 2008, there is no limitation of auditor liability in respect of death or personal injury, fraud or fraudulent misrepresentation by it or its employees. In all other instances a total aggregate limit of £2m applies. The external audit fee is £62,856; representing a net spend of £52,380 together with irrecoverable VAT of £10,476.

[2] Other audit related services relate to Mental Health Investment Standard's audit for 18/19 which is due to be submitted by September 2019

[3] Other non audit related services relate to a population health management system

6 Better Payment Practice Code

Measure of compliance	**2018-19 Number**	**2018-19 £'000**	2017-18 **Number**	2017-18 **£'000**
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	13,937	86,620	12,898	71,486
Total Non-NHS Trade Invoices paid within target	13,664	84,980	12,696	70,715
Percentage of Non-NHS Trade invoices paid within target	**98.04%**	**98.11%**	**98.43%**	**98.92%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,959	565,090	3,808	546,596
Total NHS Trade Invoices Paid within target	3,888	564,720	3,736	546,299
Percentage of NHS Trade Invoices paid within target	**98.21%**	**99.93%**	**98.11%**	**99.95%**

7. Operating Leases

7.1 As lessee

The CCG occupies property owned and managed by NHS Property Services Limited. In 2014/15, a transitional occupancy rent based on annual property cost allocations was agreed. However, in 2016/17, such property moved to market rent valuation and additional funding was received by the CCG to offset any increased cost of implementing this policy. This is reflected in Note 7.1.1.

While our arrangements with NHS Property Services Limited 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 in prior years relate to photocopiers.

Under delegated co-commissioning of primary care services arrangements, NHS Gloucestershire CCG has entered into certain financial arrangements involving the use of GP premises. These have been considered under:
IAS 17 Leases
SIC 27 Evaluating the substance of transactions involving the legal form of a lease
IFRIC 4 Determining whether an arrangement contains a lease.
The CCG has determined that these are operating leases that must be recognised, but, as there is no defined term in the arrangements entered into, it is not possible to analyse the arrangements over financial years. The financial value included in operating expenses is £5.7m

7.1.1 Payments recognised as an Expense

2018-19	**Buildings £'000**	**Other £'000**	**Total £'000**
Payments recognised as an expense			
Minimum lease payments	1,332	5	**1,337**
Total	**1,332**	**5**	**1,337**

2017-18	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense			
Minimum lease payments	1,350	5	**1,355**
Total	**1,350**	**5**	**1,355**

8 Property, plant and equipment

8.1 Asset summary by year

	2018-19			2017-18		
	Transport equipment £'000	**Information technology £'000**	**Total £'000**	Transport equipment £'000	Information technology £'000	Total £'000
Cost or valuation at 01 April	81	1,063	1,144	81	993	1,074
Additions purchased	0	70	70	0	70	70
Cost/Valuation at 31 March	**81**	**1,133**	**1,214**	**81**	**1,063**	**1,144**
Depreciation 01 April	81	694	775	81	595	676
Charged during the year	0	113	113	0	99	99
Depreciation at 31 March	**81**	**807**	**888**	**81**	**694**	**775**
Net Book Value at 31 March	**0**	**326**	**326**	**0**	**369**	**369**
Purchased	0	326	326	0	369	369
Total at 31 March	**0**	**326**	**326**	**0**	**369**	**369**
Asset financing:						
Owned	0	326	326	0	369	369
Total at 31 March	**0**	**326**	**326**	**0**	**369**	**369**

8.2 Cost or valuation of fully depreciated assets

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

	2018-19 £'000	2017-18 £'000
Transport equipment	81	81
Information technology	505	505
Total	**586**	**586**

8.3 Economic lives

	Minimum Life (years)	**Maximum Life (Years)**
Transport equipment	0	0
Information technology	1	5

9 Trade and other receivables

	Current 2018-19 £'000	Current 2017-18 £'000
NHS receivables: Revenue	2,113	1,263
NHS prepayments	23	25
NHS accrued income	386	1,174
NHS Non Contract trade receivable (i.e pass through funding)	867	-
Non-NHS and Other WGA receivables: Revenue	1,199	803
Non-NHS and Other WGA prepayments	651	445
Non-NHS and Other WGA accrued income	1,856	1,890
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	389	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	346	-
Expected credit loss allowance-receivables	(57)	(57)
VAT	114	113
Other receivables and accruals	12	12
Total Trade & other receivables	**7,899**	**5,667**
Non current receivables	-	-
Total current and non current	**7,899**	**5,667**
Included above:		
Prepaid pensions contributions	-	-

9.1 Receivables past their due date but not impaired

	2018-19 £'000			2017/18 £000s
	DHSC Group Bodies	**Non DHSC Group Bodies**	**All Receivables**	All receivables prior year
By up to three months	687	404	1,091	382
By three to six months	-	59	59	219
By more than six months	17	14	31	23
Total	**704**	**477**	**1,181**	624

9.2 Non-Current: capital analysis

	2018-19 £'000	2017-18 £'000
Capital revenue	70	70
Capital expenditure	(70)	(70)

10 Cash and cash equivalents

	2018-19 £'000	2017-18 £'000
Balance at 01 April 2018	6	17
Net change in year	3	(11)
Balance at 31 March 2019	**9**	**6**
Made up of:		
Cash with the Government Banking Service	9	6
Cash in hand	0	0
Cash and cash equivalents as in statement of financial position	**9**	6
Balance at 31 March 2019	**9**	**6**

11 Trade and other payables

	2018-19 £'000	2017-18 £'000
NHS payables: Revenue	4,201	6,282
NHS payables: Capital	70	70
NHS accruals	5,071	3,334
Non-NHS and Other WGA payables: Revenue	5,373	4,092
Non-NHS and Other WGA accruals	33,799	31,346
Non-NHS and Other WGA deferred income	2	115
Social security costs	210	178
Tax	176	145
Other payables and accruals	1,740	1,626
Total Current Trade & Other Payables	**50,642**	**47,188**
Non current	-	-
Total current and non-current Trade & Other Payables	**50,642**	**47,188**

Other payables include £1,120k of outstanding pension contributions at 31 March 2019 (2017/18: £1,079k)

12 Provisions

	2018-19 £'000	2017-18 £'000
Current		
Continuing care	915	925
Other	1,961	1,712
Total	**2,876**	**2,637**
Non current	**0**	**0**
Total current and non-current	**2,876**	**2,637**

	2018-19			2017-18		
	Continuing Care £'000	**Other £'000**	**Total £'000**	Continuing Care £'000	Other £'000	Total £'000
Balance at 01 April	**925**	**1,712**	**2,637**	**800**	**912**	**1,712**
Arising during the year	550	655	1,205	950	940	1,890
Utilised during the year	(560)	(295)	(855)	(825)	(140)	(965)
Reversed unused	0	(111)	(111)	0	0	0
Unwinding of discount	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0
Balance at 31 March	**915**	**1,961**	**2,876**	**925**	**1,712**	**2,637**
Expected timing of cash flows:						
Within one year	915	1,961	2,876	925	1,712	2,637
Between one and five years	0	0	0	0	0	0
After five years	0	0	0	0	0	0
Balance at 31 March	**915**	**1,961**	**2,876**	**925**	**1,712**	**2,637**

The continuing care provision of £915k (2017-18: £925k) is for costs expected to be incurred in relation to backdated claims received by the CCG since 1st April 2013 for NHS England hold a provision for all backdated claims received prior to 1 April 2013 which totals £1,816k (2017-18: £2,515k)

The claims outstanding at 31 March 2019 are expected to be paid within the 2019/20 financial year

Provisions made under the 'Other' category relates to potential primary care costs regarding practice development, tax related items and other legal and contractual issues

Legal claims are calculated from the number of claims currently lodged with the NHS Resolution and the probabilities provided by them.

13 Financial instruments

The accounting policy regarding financial instruments has changed since 2017/18, IFRS 9 being adopted in full during 2018/19 (replacing IAS 39) and the new policy is disclosed under notes 1.12 to 1.14

13.1 Financial risk management

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

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

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

13.1.1 Currency risk

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

13.1.2 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.

13.1.3 Credit risk

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

13.1.4 Liquidity risk

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

13.1.5 Financial Instruments

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

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

	Cash And Cash Equivalents	Trade and other receivables - NHSE bodies	Trade and other receivables - other DHSC	Trade and other receivables - external	Other financial assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Assets held at Amortised cost	6	1,315	2,087	1,728	12	**5,142**
Total at 31st March 2018	**6**	**1,315**	**2,087**	**1,728**	**12**	**5,142**
Classification under IFRS 9 as at 1st April 2018						
Financial Assets measured at amortised cost	6	1,315	2,087	1,728	12	**5,142**
Total at 1st April 2018	6	1,315	2,087	1,728	12	**5,142**
Change in carrying amount	-	-	-	-	-	**-**

13.3 Financial assets

	Financial Assets measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Trade and other receivables with NHSE bodies	806	-	**806**
Trade and other receivables with other DHSC group bodies	4,321	-	**4,321**
Trade and other receivables with external bodies	2,030	-	**2,030**
Other financial assets	12	-	**12**
Cash and cash equivalents	9	-	**9**
Total at 31 March 2019	**7,178**	**-**	**7,178**

13.4 Movement in loss allowances due to application of IFRS 9

	Trade and other receivables -NHSE bodies	Trade and other receivables - other DHSC group bodies	Trade and other receivables - external	Other financial assets	Total
		£000s	£000s	£000s	£000s
Impairment and provisions allowances under IAS 39 as at 31st March 2018					
Financial Assets held at Amortised cost (ie the 1718 Closing Provision)	-	-	(57)	-	(57)
Total at 31st March 2018	**-**	**-**	**(57)**	**-**	**(57)**
Loss allowance under IFRS 9 as at 1st April 2018					
Financial Assets measured at amortised cost	-	-	(57)	-	(57)
Total at 1st April 2018	**-**	**-**	**(57)**	**-**	**(57)**
Change in loss allowance arising from application of IFRS 9	-	-	-	-	-

13.5 Impact of Application of IFRS 9 on financial Liabilities at 1 April 2018

	Trade and other payables - NHSE bodies	Trade and other payables - other DHSC group bodies	Trade and other payables - external	Other borrowings (including finance lease obligations)	Other financial liabilities	Total
		£000s	£000s	£000s	£000s	£000s
Classification under IAS 39 as at 31st March 2018						
Financial Liabilities held at Amortised cost	426	21,918	22,770	-	1,637	**46,325**
Total at 31st March 2018	**426**	**21,918**	**22,770**	**-**	**1,637**	**46,325**
Classification under IFRS 9 as at 1st April 2018						
Financial Liabilities measured at amortised cost	426	21,918	22,770	-	1,637	**46,325**
Total at 1st April 2018	**426**	**21,918**	**22,770**	**-**	**1,637**	**46,325**
Change in carrying amount	**-**	**-**	**-**	**-**	**-**	**-**

13.6 Financial liabilities

	Financial Liabilities measured at amortised cost 2018-19 £'000	Equity Instruments designated at FVOCI 2018-19 £'000	Total 2018-19 £'000
Trade and other payables with NHSE bodies	1,062	-	**1,062**
Trade and other payables with other DHSC group bodies	24,211	-	**24,211**
Trade and other payables with external bodies	23,242	-	**23,242**
Other financial liabilities	1,740	-	**1,740**
Total at 31 March 2019	**50,255**	**-**	**50,255**

14 Operating Segments

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

15 Pooled budgets

The pooled budget relates to integrated community equipment services with Gloucestershire County Council
This service has been running for a number of years and buys, delivers, collects, maintains and decontaminates equipment for patients in their own homes. This service is jointly commissioned by the CCG, with Gloucestershire County Council, who are the lead commissioner for the service.

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

	2018-19 £000	2017-18 £000
Income	(3,461)	(3,359)
Expenditure	3,461	3,359

16 Losses and special payments

16.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Administrative write-offs	0	0	1	0
Total	**0**	**0**	**1**	**0**

16.2 Special payments

	Total Number of Cases 2018-19 Number	Total Value of Cases 2018-19 £'000	Total Number of Cases 2017-18 Number	Total Value of Cases 2017-18 £'000
Ex Gratia Payments	2	1	0	0
Total	**2**	**1**	**0**	**0**

17 Events after the end of the reporting period

There are no events to report after the end of the reporting period.

18 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.

	2018/19 Payments to Related Party				2017/18 Payments to Related Party			
	Payments under delegated co-commissioning arrangements	Drugs reimbursed	Other payments	**Total Payments**	Payments under delegated co-commissioning arrangements	Drugs reimbursed	Other payments	Total Payments
	£000	£000	£000	**£000**	£000	£000	£000	£000
Dr Caroline Bennett (CCG Member/GP Locality Lead) *Partner - Cotswold Medical Practice*	1,486	711	187	**2,384**	1,394	720	183	**2,297**
Dr William Haynes (CCG Member/GP Locality Lead) *Partner - Hadwen Medical Practice*	2,213	95	367	**2,675**	1,863	86	336	**2,285**
Dr Hein Le Roux (CCG Member/Deputy Clinical Chair) *Phoenix Surgery(17/18) and Churchdown Surgery (18/19)*	1,842	63	186	**2,091**	1,458	124	124	**1,706**
Dr Andrew Seymour (CCG Deputy Clinical Chair until 30/4/16; Clinical Chair from 01/05/16) *Partner - Aspen Medical Practice**	3,903	125	554	**4,582**	1,351	56	112	**1,519**
Dr Jeremy Welch (CCG Member/GP Locality Lead) *Partner - Mythe Medical Practice*	1,584	88	169	**1,841**	1,515	69	166	**1,750**
Dr Will Miles (CCG Member/GP Locality Lead from 01/04/18) *GP Partner - The Portland Practice*	1,559	66	140	**1,765**	-	-	-	**-**
Dr Alan Gwynn (CCG Member/GP Locality Lead from 01/04/17) *GP Partner - Cirencester Health Group*	1,005	43	56	**1,104**	761	28	69	**858**
Dr Sheena Yerburgh (CCG Member/GP Locality Lead from 01/04/17) *GP Partner - Prices Mill*	1,050	34	125	**1,209**	1,001	24	119	**1,144**
Dr Lawrence Fielder (CCG Member/GP Locality Lead from 01/06/17) *GP Partner - Brunston*	743	369	65	**1,177**	747	350	56	**1,153**
Dr Lesley Jordan - Secondary Care Doctor advisor to the CCG (from 03/07/17) *Royal United Hospital Bath NHS Foundation Trust*	-	-	31	**31**	-	-	11	**11**

** Dr Andrew Seymour's Practice has merged with three others as of 1st April 2018 which explains the significant variation in payments between the years*

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
- NHS England;
- NHS Foundation Trusts;
- NHS Trusts;
- NHS Litigation Authority; and,
- NHS Business Services Authority.

Mr Colin Greaves (a lay member and Audit Committee Chair at the CCG) has been a Council of Governors member of Gloucestershire Hospitals NHS FT since October 2016.

Ellen Rule (Director of Transformation and Service redesign) is a member of the NICE Technology Appraisal Committee

Julie Clatworthy (Governing Body Registered Nurse) is a standing member of the Quality Standards Advisory Committee at NICE

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

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